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EQUITY AND FREEDOM IN HEALTH CARE

edited by

A. Benos, H.-U. Deppe, St. Iliffe

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ADDRESS IAHP: Klinikum der Johann Wolfgang Goethe-Universität, Inst. für Medizinische Soziologie, Theordor-Stern-Kai 7, 60590 Frankfurt a.M., Germany, Tel.: 0049 69 6301-7610, FAX: 0049 69 6301-6621, E-Mail: H.U.Deppe@em.uni-frankfurt.de

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Abteilung für Medizinische Soziologie
Leiter: Prof. Dr. Hans-Ulrich Deppe

Zentrum der Psychosozialen Grundlagen der Medizin
Klinikum der Johann Wolfgang Goethe-Universität
Institut für Medizinische Soziologie
Theodor-Stern-Kai 7
60590 Frankfurt am Main
Telefon (0 69) 63 01 - 76 10
Fax (0 69) 63 01 - 66 21

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EQUITY AND FREEDOM IN HEALTH CARE UNDER NEOLIBERAL DICTATORSHIP

Hans-Ulrich Deppe

Equity and freedom in health care is an ambitious title. Equity is a concept which is not well defined, but for freedom we have many definitions. Both concepts have a general character, are overall goals, have historical impact and analytical depth.

1. **Equity** is not given by nature. In nature we have - as Darwin found out - "the survival of the fittest". And that means constitutively inequality, selection and struggle. This is not compatible with equity. What we want to speak about is equity in human life and that means social equity. Social equity is historically mediated and the result of human communication, work and power. What it means concretely is changing. It depends upon the economic, political and ideological structures of a society.

In social reality differences in social class, gender, geographical location, ethnic or religious group and age reflect differences in social privilege. Striking differences in health between richer and poorer nations have long been recorded. A child born in a developing country of Africa, Asia or Latin America is roughly ten times more likely to die before reaching the age of five than a child born in Europe or North America. Comparable gaps exist within countries: the life expectancy at birth of the most disadvantaged segment of the population in Mexico is 20 years less than that of the most affluent segment. Then there are the gender, ethnic and age-group gaps. A study in India showed that girl children aged between one and 23 months were almost twice as likely to die by the age of two as were boy children; it concluded that the most likely explanation was the different behaviour of families towards boy and girl children, rather than any biological differences. In 1990, the death rates for non-white men in South Africa were double those of men of European background in the same country. The US Medicaid programme was designed to ensure health care for disadvantaged children (and their mothers), while Medicare ensures health care for the elderly regardless of income. Not only is Medicare far better funded than Medicaid, but more than two-third of Medicaid funds go to care for elderly and for disabled adults. All these gaps are widening and worsening in most countries of the world.

With this background today social equity means something like "fairness" (John Rawls). It means that people´s needs and necessities, rather than social privileges, guide the distribution of opportunities for well-being. It is orientated to all and not to some. We have to look at equity in terms of equal access to health care and in terms of its contribution to equality in health and social consequences of illness.[1] Political decisions are necessary to create and stabilize social equity. This principle lies at the heart of a global initiative launched last year by the World Health Organization (WHO) and the Swedish International Development Cooperation Agency (Sida), whose goal is to promote and support practical policies and action to reduce avoidable social gaps in health and health care between groups which live at different levels of social privilege. [2]

2. It is not easy to find a plausible **indicator**, which makes social equity concrete and transparent. I think the social worth (value) of equity can be measured in the way in which a society treats its most vulnerable members. That demands priority to the sickest. If we do not understand what it means to take the rights of the ill and

diseased seriously then it is unlikely that we will do so for others who lack the strength or ability to defend themselves. This seems to be what good politics and good social medicine are all about.

3. The WHO defines health in terms of physical, social and mental well-being. Producing health and caring for sickness and illness makes us more independent, which means more free. Health care is a social instrument to develop more human freedom, **freedom through health care.**

4. **Freedom** - the chance of freedom, freedom of choice - in human societies is not given by nature. Freedom assumes a social subject. The philosopher Friedrich Wilhelm Hegel formulated: Freedom is the recognition of the necessity. Meanwhile we know that conciousness alone is not enough, but perhaps a first step. In the context of freedom we should try to answer some questions. Freedom **from** what? People are dependent on their existential conditions of life and its social organisation. Freedom at first means to become independent from such social needs. Over this freedom is a necessarily to manage this process. Freedom **for** what? This question demands the dimension of autonomy and selfdetermination - not to be determined by nature or other men. And not least the question: Freedom **for some** or freedom **for all**? We know that modern society can give freedom to some but until now not to all. And that freedom for some rests mostly on the shoulders of many. Socialism is a result of this historical experience and was an experiment to change it. In a slight modification of Rosa Luxemburg, I would say: "Freedom in a democracy has to include the freedom of the other".

5. **Freedom in health care**, the freedom to choose special forms of treatments is not easy, because in medicine and health care many highly differentiated necessities exist. Therefore we need confidence in experts. Freedom of choice is most obvious in the access to health care. That means
- if all members of a society can enter the health care system,
- if people can select their physician or expert, whom they trust,
- if they can choose different forms of medicine: like traditional medicine or alternative medicine.

And over this
- if people have the freedom of choice in respect of equal treatment for equal need,
- and last but not least, if the patients are acknowledged and accepted as autonomous subjects.

We know that this freedom in reality is very limited, mostly by economic but also by educational and regional conditions. Often it is confined by the social structure of a society. Within the contemporary neoliberal paradigm the market and competition shall expand and enlarge freedom in health care. But only for some.

6. In the bourgeois society freedom is a quality which corresponds closely with the market - the **free market**. The market needs free labour forces, free and private properties, free individuals and unlimitted regions to expend. Under such conditions the market distributes the colletively produced values of a society. This distribution depends mainly on private interests. Of course the market itself has no interests - but there is no real market without interests. And the market in combination with competition produces selection, polarisation and egoism - similar to that which Darwin described for nature. The free market itself as an economic instrument is not able to construct social equity. For that we need political decisions which are orientated to the society as a hole.

The development of the market society started politically with the French revolution. And the French revolutionaries knew that "liberté" alone is not enough and so they added "fraternité" and "egalité". This knowledge realized itself in the welfare states of the western European market societies. Under the pressure of the working class bourgeoisie itself had to build up different forms of welfare states as barriers against the furious forces of the market. And it was not only the welfare states but also the modern human rights. Over this the bourgeois society tried to introduce different forms of politically controlled markets. It was and is until now a reaction to the exploding market forces, which seem to be unchangeable "physical obligations". But the social organization of health care is not only a reaction to market forces, it too is a condition for the partial stabilization and pacification of the market society.

In a democratic society **freedom and equity belong together**. They are man- made and are a historical result of human progress. Social equity is a basis and assumption for social freedom in a democracy - the opportunity of freedom for all. Both are concerned with social needs like health and health care. The freedom to have good, competent health care in individual situations should be equal. This idea is constitutive for our European welfare states, which are relevant parts of our civilisation. And in December 1995 during the mass strike in France, which was directed against the social cuts and reductions in the social health insurance, Pierre Bourdieu, the French philosopher, formulated in a speach to the striking people: "I will declare our support to all of you, who are struggling against the destruction of our civilisation - a civilisation which is strongly combined with the existence of the public service, what means the republican equality of right, the right of education, the right of health, of culture, of research, of art and especially the right of work".[3] He critizised the power that the market and consumers have occupied within the State. He critizised especially the economists of the World Bank and the International Monetary Fund, who urge us powerfully to accept the verdicts of the new Leviathan, the financial markets. We as scientists have to show and demonstrate the abstract and reduced knowledge of the market economy as a compensation for missing future humantarian perspectives. We as health workers have to show that the patient is not a homo economicus. We have to point out the limits of the market economy. And we have to develop knowledge against it, which has more respect for people and their realities. We have to make clear that human and social rights, like the right to health which is rooted in social equity and freedom, cannot be economized. If they are brought to the market nevertheless, they will be destroyed and with them our social culture and political civilisation. [4]

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Address for correspondence

Prof. Dr. Hans-Ulrich Deppe
Universitätsklinikum
Institut für Medizinische Soziologie
Theodor-Stern-Kai 7
60590 Frankfurt a. M.
Germany
Tel.: +49 69 6301 7610
Fax: +49 69 6301 6621
H.U.Deppe@em.uni-frankfurt.de

THE RETREAT FROM EQUITY

Implications of the shift towards a primary-care led NHS.

Steve Iliffe

A PRIMARY CARE LED NHS?

Primary care does not exist, being an abstraction invented by policy experts to describe the patchwork of services in the community that provide the citizen with access to medical care. The largest component of the patchwork , in terms of breadth of contact with the population, is general practice, but community nursing in different forms, and professions allied to medicine contribute to the overall pattern through Community Trusts. This dominance of general practice encourages some doctors to misinterpret their status as the totality of primary care, seeing all other professional groups as subordinate in function and themselves in the central role. General practice can be viewed differently, as a the most problematic element in the patchwork by virtue of its size and style of organisation.

From the perspective of the population's health, general practice is ill-equipped to become the foundation of a reconfigured health service, since the quality of medical care provided by it is so variable and so difficult to change. As a whole general practitioners do well what they are trained for - diagnosis of significant medical problems - but are less effective in the management of long-term illness, and have limited capacity to prevent ill-health, despite considerable efforts to re-train and re-orientate over the last two decades.

One legacy of the diagnostic orientation is a close relationship to the pharmaceutical industry, which remains a major contributor to continuing medical education and underpins the focus on the individual patient, the tendency to medicalise problems and the reliance on chemotherapeutic solutions to problems. Not only does this pattern of biases lead to the neglect of the 'untreatable' - including social dimensions of ill-health like disability and irremediable disorders like dementia - but it minimises any sense of 'public health' and emphasises instead the anecdotal recall of problem-solving experiences.

These experiences are themselves changing in character and narrowing in focus. Since 1980 there has been a slow retreat by general practitioners from acute medicine, with a recent rapid withdrawal from out-of-hours work and the abandonment of much maternity care. The balance has shifted away from acute medical care, where general practitioners apply formidable diagnostic and problem-solving experience, towards the management of chronic disorders packaged together with individual and group preventive work, where skills are more limited. The concomitant change in hospital medicine is in the increase in use of A&E departments, the reduction in in-patient stays and the recent sudden rise in emergency admissions.

Neither the background pattern of skills and achievements of general practice, nor the recent changes in work content appear to favour the assumption of a leading role in the NHS by this section of the medical profession. Why should a group of professionals that is refocussing on chronic disease management and responses to risk

factors be seen as more competent to direct the development of services than those who take a wider view of population needs?

Whilst this may a logical objection to the notion of a primary care led NHS, political imperatives from both right and left collude with professional ambition and converge on this policy option. The current government favours an individualist approach to health and a commercial approach to service organisation, with the result that the idea of individual doctors buying specialist care for individual patients, or whole groups in a job-lot, has particular attraction. Within the opposition the objective of provider capture of policy development is pursued energetically by those advocating the leading role of general practitioners in the application of public health principles, despite the evidence of a decade or more that such a role is not sought by the great majority of the profession. Both camps seek to give general practice a vanguard position it does not merit, but only one - the market perspective - has gained influence and impact.

THE NHS REFORMS

The National Health Service is being changed from a State monopoly of medical care organised through a command-and-control structure to a devolved network of 'providers' competing for public funds in a mixed economy of medical care. Britain's general practitioners have been used as both a model of and a lever for this change towards a managed market because they have never been integrated into the control structure of the NHS, but instead have remained contractors used by the Department of Health to provide a protective screen around its hospitals.

General practice organised as a franchise has allowed the NHS to develop a system of primary care of adequate quality (except, perhaps,in the inner cities) at relatively low cost, whilst doctors in primary care have had the economic risks of practice minimised through salary elements in their reimbursement and subsidy of premises and staff costs. The success of this approach may have been one of the factors prompting the government to re-configure the NHS hospital service as a network of Trusts contracted to purchasing authorities.

Current thinking about a primary-care led NHS suggests that general practice organised as a franchise can effectively manage the market for specialist service,itself re-organised as a franchise, in the most cost-effective way. This paper argues that, even if this hitherto untested market management function can be fulfilled by primary care, the result will be greater variations in the quantity and quality of medical care to the population than exist at the moment, and the abandonment of equity as a goal of health care policy.

THE INTERNAL MARKET AND GENERAL PRACTICE

The 1990 GP contract was part of a broader market reform of the NHS which includes plans that would allow larger general practices to hold their own budgets to by a defined range of services from specialists working in hospitals - the fundholding option. In effect this meant that some general practice franchisees could opt to extend their local autonomy even further, at the price of running greater risks, in order to catalyse the internal

market in the NHS. In a sense this promotion of fundholding represents the creation of a 'super franchise', in which the subsidies to general practice are greatly increased, alongside the responsibilities and risks, with the incentive for general practitioners to join being both the possibility of improving patient care and the potential for making greater profits.

The 'super franchise' option has re-introduced competition within general practitioners, since successful fundholders would provide better services to patients than non-fundholders whilst retaining surplus funds for development of practice premises. This competitive threat poses a challenge to the equitable provision of medical care in Britain because fundholding may :

* enhance the efficiency of 'better' practices at the expense of weaker ones;

* further transfer some medication costs to users with a consequent increase in 'non-compliance' in those with low incomes;

* redirect funds from deprived areas to more affluent areas through open and hidden administrative costs;

* favour some patients before others regardless of clinical need;

* be unable to adhere to a public health agenda;

* substitute generalist for specialist care inappropriately;

* encourage enrollment in private health insurance programmes and reduce the critical pressure on the NHS exerted by the affluent and educated;

* create controlling institutions that serve the interests of a professional group and exclude public influence.

Whilst a few general practitioners embraced the concept of fund holding with enthusiasm at the outset , there was initially widespread concern amongst general practitioners that the administrative structure required would become a considerable extra burden for busy practices that few were in a position to carry . The administrative overload has been circumvented by cash support for investment in management skills and information technology, so that an increasing number of general practitioners have been drawn towards fund holding.

This level of investment immediately separates fundholders from non-fundholders, whose subsidies for computerisation and practice management are less, and provides fundholders with efficient internal systems that may enhance accessibility (through better appointment systems and time management), improve clinical records (through the need to capture clinical data for costing purposes) and increase practice income through higher rates of claiming fees for items of service. These efficiency gains may be spin-off from investment in management systems, and favour those practices that are already better organised at the expense of those that are not.

So far the only area where fundholders have a demonstrable advantage over traditional franchisees is in reducing prescribing costs . This is a government objective, but success in cost containment tells us nothing about either the quality of care, which may decline as medicine costs are cut, nor the long term economic costs of short term savings on prescribing, which may be considerable. Since medication costs are being transferred to patients through higher prescription charges and a widening range of over-the-counter (OTC) medicines, the likely end result of downward pressure on prescribing costs is greater expenditure on medication by those who can afford them, and less use of medication by those who cannot.

The economic costs of fundholding are substantial, and include both open costs like management fees, subsidies for computerisation and administrative costs in the practice from the billing and contract review processes, as well as hidden costs like staff time in Family Health Service Authorities, Trust hospitals and the Audit Commission The opportunity costs of developing fundholding are not debated , but diverting resources to already well endowed shire county practices to enhance their purchasing power whilst not spending development money on primary care services in deprived areas (outside the favoured London Implementation Zone) is a further challenge to equity.

The political costs may be equally significant, given the damage done to equity by fund holders buying speedier treatment for their patients - 'fast tracking' - which appears impossible to prove but is accepted as fact whenever fundholders and provider units speak off the record.

Fundholders are as much a threat as an opportunity for local health planning. Fundholders' decisions about placing resources are primarily budget-led because the pressure to avoid overspending is so great. Overspent fundholders may simply lack the money to adhere to wider health policies, even if they want to. Adverse selection of expensive patients may have a negative impact on uptake of immunisation amongst children, for example, or on the workload of mental health services in a locality.

The costs of specialist care may be reduced by better chronic disease management in the community, and through primary and secondary prevention in general practice, but we cannot be certain about that and the opposite may be true. Good quality primary care may identify more problems amenable to treatment by specialists, whilst inadequate screening, health maintenance and disease management by cost-conscious general practitioners may create more problems for specialists, requiring more money not less to solve them. A mechanism that encourages reduced referral or prescribing on the assumption that other forms of treatment will than develop to make this reduction possible is running far ahead of the evidence.

Private health insurance may prove a useful tool for fundholders, since patients using such insurance may save the fundholder money that can be spent on those without insurance. The privately insured patient then appears to be a good Samaritan to the less affluent, but covertly diverts specialist expertise away from the public sector (especially in surgery) whilst diminishing the critical impact of the educated and affluent on the quality of NHS care.

Finally, the coalescence of fundholding practices into consortia will create mini-Health Authorities controlled by general practitioners, where there is no prospect of institutionalised public influence or control. Whilst this is absent from current purchasing authorities, there is at least the prospect of an easy adaptation of the existing structure to democratic input, and even to merger with local authorities. It is difficult to see how fundholding consortia could match this prospect, except perhaps through the adoption of the kind of 'community oriented' outreach to local populations tried in the USA.

BREAKING THE GENERAL PRACTITIONER MONOPOLY

Fundholding was meant to kick-start the internal market and make hospitals more competitive. It has done that to some extent, but it has also triggered resistance amongst those who saw fundholding for what it could be - competition amongst British-style Health Maintenance Organisations. The result was a confusing conflict between market oriented fundholding and its socialised rival, locality commissioning, in which both sides expressed their common aim - to shape the health service according to their own interests.

This was not what the Government wanted. Fundholding had become to its GP advocates an end, not a means, and locality commissioning had restored some sense of planning to the idea of a primary care led NHS. The political problem for the government in the early 1990's was clear. General practitioners did not want to be subject to competition, but instead sought management positions in the managed market. The solution was equally clear. The monopoly that General Practitioners had over primary care had to be broken, so that they would be forced into competition with each other and with other primary care providers. Then the market mechanisms for a privatised health service would be nearly complete, and the security provided by a certain role in a service with fixed boundaries would be replaced by the insecurities of competition in services with fluid boundaries. Stephen Dorrell hinted at the shape of things to come early in 1996 in an issue of Purchasing Bulletin when he used two pages to describe the potential of a primary care led NHS without mentioning general practice once, but nobody in the profession took the hint.

The spate of documents released at the end of 1996 that fed into the Primary Care Act passed at the end of the Major government revealed the solution. The policy problem for the government in its plans to privatise the health service lay in general practice. General practitioners would therefore be given three choices. Either stay as independent contractors to Health Authorities, but working under increasingly tight control and direction, or take extra risks and responsibilities by becoming mini-Trusts, or join existing Trusts as salaried employees.

If the government is successful those general practitioners who retain their traditional relationship to the Health Authorities will need to work within increasingly complex rules which distinguish between 'core' and 'non-core' tasks, and will spend increasing amounts of time on the administration needed to maximise their income from a widening range of fees for specific services. The days of the open-ended and vaguely defined contract are over, and the age of quality standards, guidelines and accountability has begun. The consolation prize is security of tenure, for these doctors will remain on the Medical List where their contracts are guaranteed up to the age of 70.

Those who opt for status as mini-Trusts will not only compete with other Trusts to provide primary care, but will eventually loose their security of tenure. No more jobs for life! The ambitious GP-Trust will then need to fend off competition from the local Acute Hospital Trust, or the Community Trust, either or both of which may offer primary care services. They will be able to do this because they attract general practitioners into their organisation, employing them on a salaried basis, but probably on relatively short term contracts. Those practices which opt for linkage to existing Trusts will be sheltering under expansive wings, but at the price of their GPs loosing their autonomy and security of tenure.

The result will be the end of general practice as a nationwide system for providing medical care in the community distinct from other, more specialised services. It will continue in its traditional form in some parts, but its advocates will struggle to survive and as time passes may well seek shelter in bigger organisations - just as fundholders have tended to aggregate into larger units. Generalism will continue in many forms, and no wise Trust will dispense with it because European and American experience teaches that direct public access to specialist care is expensive, so there will still be a place for general practitioners inside acute and community Trusts.

Is this a problem? Not at first sight, because the separation of general practice from hospital medicine on one hand, and other community services on the other, has bedeviled the growth and development of good quality medical care for decades. Compartmentalisation of services has meant unnatural compartmentalisation of patients' problems, with only limited escape from this problem through repeated but usually disappointing attempts at joint working. A single service that combines general and specialist skills, however organised, may seem a more attractive option than the old divide between generalists and specialists.

There are two particularly obvious hazards in this process. The first is that Trusts may develop primary care to retaliate against fundholders who have destabilised Trusts through contract shifting. A large and aggressive Acute Trust could recruit the patient base from under fundholding without necessarily being able to deliver primary care of the same quality. The American experience of such competition between providers is that the bad drives out the good, so whilst many would gain much pleasure from fundholders' discomfort, the damage to primary care might be less desirable.

The second hazard is adverse selection, with competing primary care providers looking for healthy people who make little use of services and avoiding the iller, older, poorer population which costs more to service. Here the beleaguered fundholders may find a defence against aggressive Trusts, creaming of the younger and more affluent with offers of physiotherapy and counseling in-house whilst the Trust's primary care services are left with the seriously sick. The case mix matters, because funding for the illest people is unlikely to match their needs, forcing Trusts with primary care ambitions to provide limited services to those who need most. The experience of cash-strapped American public hospitals struggling with escalating demand and dwindling staff morale would then be repeated in Britain.

Can Britain's new Labour government escape this legacy? Probably not, given the interests mobilising behind it and the obvious benefits of local mergers of generalists and specialists. But it could keep overtly commercial

players out, maintaining a truly 'internal' market whilst controlling the process of innovation tightly - through the Health Authorities - to minimise destructive competition at local level. Trusts which can negotiate local deals with the majority of general practitioners to create a single service should be encouraged to do so. Attempts to offset the power of fundholders by developing alternative sources of primary care should be monitored closely to avoid poor services emerging for poor people, and the capitation basis for funding services should be modified to reflect patterns of illness more accurately. Above all, the public needs to be involved in the debate about the future provision of health services, with a Labour government emphasising the issues of needs, justice and equity.

CONCLUSION

The possibility of a primary care led NHS has risen towards the top of the political agenda on at least two occasions since 1911, but has always been a weak idea trying to become a core concept. The nature of general practice and of general practitioners militates against an inversion of the existing power relationship between hospital specialists and generalists, even though fundholding appears to offer this opportunity. Fundholding could further erode any prospect of equitable provision of medical care to the population because it favours unequal development of services and unequal treatment of individuals. The political imperative to distribute resources justly and according to need is best met through a policy and planning mechanism in which the power of those with an overview of the public's health balances the power of those in daily contact with a population of individuals, such as locality commissioning.

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Address for correspondence

Dr. Steve Iliffe
Dept. of Primary Care & Population Sciences
UCLMS & RFHSM
Royal Free Hospital School of Medicine
Rowland Hill Street
London NW3 2PF
England
Tel.: +44 171 830 2393
Fax: +44 171 830 2339
s.liffe@ucl.ac.uk

THE BRITISH EXPERIMENT WITH GP FUNDHOLDING AND ITS EFFECTS ON EQUITY OF ACCESS TO HEALTH CARE

James Munro

Introduction

Of the policy changes heralded by the British government's 1989 white paper *Working for patients* and introduced into the NHS in 1991, general practitioner fundholding has perhaps been — and still remains — the most controversial.

From the start, the idea of giving doctors fixed budgets to pay for the care of their patients raised a host of concerns. How would the budget be set? Would patients still receive the care they needed? What would happen if the budget ran out? Would the patients of non-fundholders be disadvantaged? These questions, and others, were posed and debated vigorously by media commentators, politicians, patient organisations and policy analysts.

The high public profile of the fundholding scheme has been associated with a relatively high research profile. Of all the elements of the 1991 reform package, fundholding has attracted the greatest attention from researchers. However, most of this research has addressed questions relating to referral rates, prescribing activity and the costs of the scheme. Very little has focused on considerations of equity.

Yet fundholding has been controversial precisely because of the potential it holds to threaten the equity of access to care which many people hold to be a core value of the NHS, and which has long been pursued as an explicit policy goal.

In this paper I outline the incentives inherent in fundholding which represent threats to equity, and review some of the available evidence on whether fundholding really has damaged equity of access to care.

Since the election of a Labour government in Britain in May 1997, the future of fundholding has been placed in doubt. Nonetheless, the issues examined here will remain important whatever form of purchasing replaces fundholding. In particular, the question of biased patient selection will remain important in any future organisation of health care in which those paying for care are able to select, to any degree, which patients they will cover. Health authorities which must pay for the health care of a population defined geographically can exert little or no selection. By contrast, fundholders, total purchasing projects, multifunds and other forms of purchasing based on lists of "enrollees" can potentially be very selective towards their patients, and will always have an incentive to do so in order to minimise costs.

The extent to which purchasers are able or willing to respond to the various incentives discussed here remains to be shown, and will vary from place to place and from time to time. But so long as equity of access to care remains a core value for the health service, it will be important to monitor current and future forms of organisation to ensure that they do not lead to an inequitable distribution of care.

The fundholding scheme

Origin

There is some debate over the real origins of the fundholding policy. It emerged from the Government's NHS review of 1988 and was formally set out, as "the practice budgets scheme", in the 1989 white paper *Working for Patients*.[1] The then Secretary of State for Health, Kenneth Clarke, has since claimed the idea as his own, asserting that 'on holiday on a headland near Pontevedra in Galicia, I came up with GP fundholders'.[2]

Yet it is clear that the notion of devolving budgets to general practitioners for some elements of care has a much longer history than this. The Department of Health had been investigating ideas for reforming primary care in the early 1980s, and had examined the US experience of Health Maintenance Organisations (HMOs). The idea of budgets held by primary care doctors had been proposed in the UK in a speculative way by Marshall Marinker[3], and Alan Maynard had been developing proposals along similar lines at more or less the same time.[4]

Aims of the scheme

The aims of "the practice budgets scheme" were not explicitly stated in *Working for Patients*. However, the white paper did suggest that the scheme would provide both GPs and hospitals with an incentive to "put patients first", and that the result would be "better care for patients, shorter waiting times, and better value for money". No mention was made of the possibility of perverse incentives provided by the scheme, nor specifically of the incentive to avoid or reduce expenditure on costly patients.

However, further detail was set out in *Working Paper 3*, one of a series of implementation papers which followed shortly after the publication of the white paper.[5] In paragraph 6.2 of the working paper, the Government explicitly acknowledged, but dismissed, the risk of adverse selection.

> Practices participating in the scheme will not be expected to be selective over who may be registered with them... Budgets will be set rationally and fairly to ensure that doctors have no reason to refuse patients for financial reasons... The Government does not believe that doctors will seek to remove patients from their lists on budgetary grounds nor be slow to accept patients.

The way in which the scheme would minimise the incentive for doctors to avoid costly patients was outlined in paragraph 3.9 of the working paper.

> There will be rare cases in which the cost of necessary hospital treatment falling within the scope of the scheme would be exceptionally high or represent an unpredictable call on the GP's budget either due to a succession of one-off treatments or continuing care. Such cases should not be allowed to distort hospital referral practices and budgetary concerns cannot be allowed to affect good patient care. The Government therefore proposes that costs for any individual within a year in excess of, say, £5000 will be charged to the patient's DHA's budget.

This "stop loss" arrangement, designed to reduce the possibility of adverse patient selection, was in fact introduced exactly as *Working Paper 3* had stated. In 1994 the limit to the cost of any one patient to the fund in a single year was raised from £5000 to £6000.

The Government's view was that the stop loss mechanism, taken together with the arrangements for setting budgets, provided a sufficient safeguard to avoid patient selection. This was clearly expressed in the introduction to the working paper.

> The scheme will be structured to ensure that GPs have no financial incentives to refuse to treat any categories of patients or accept them onto their lists.

Criteria for joining the scheme

Fundholding has been a voluntary scheme which practices may choose to join, or not, as they wish. The original proposals published in *Working Paper 3* gave only two criteria for participation: that practices should have a registered list of at least 11,000 patients; and "an ability to manage budgets".[5]

In fact, the first of these criteria was relaxed so that in 1991 first wave fundholders needed a minimum list size of 9,000 to join the scheme. The required minimum list size was further lowered in subsequent years so that, by April 1996, a list size of only 5,000 patients was necessary.

What the fund covers

In the scheme introduced in April 1991 which, in the light of the subsequent introduction of community fundholding and total purchasing schemes, has become known as "standard fundholding", the budget allocated to fundholders was to purchase the following services for patients:

- a defined list of hospital services, including most elective surgery and almost all outpatient attendances;
- community health services, such as visits from community nurses and health visitors, community mental health care and community or outpatient services for people with learning disability;
- direct access services, such as physiotherapy;
- diagnostic tests and investigations provided on an outpatient basis;
- drugs and appliances prescribed by the GP.

In addition, the fund contains an element to pay for staff employed by the practice who are not involved in managing the fund. A separate management allowance to the practice is allocated to cover the costs of managing the fund itself.

In 1993/94, a typical standard fundholding practice was responsible for a total fund budget of about £1.7m.[6] Of this sum, the Audit Commission estimated that about 55 per cent would be spent on hospital and community services, 38 per cent on prescribing and 7 per cent on practice staff.

Potential threats to equity

It is clear from the discussion above that, in creating the fundholding scheme, the Government's purpose was to introduce a structure of financial incentives which would influence the behaviour of both general practitioners and secondary care providers. Specifically, the incentives were intended to encourage cost-consciousness, efficiency, and innovation on the part of both primary and secondary care.

But apart from these generally positive effects, it is clear that any such system may also introduce incentives for actors to behave in ways contrary to the intentions of the policymakers — so-called "perverse incentives". The fundholding scheme introduced a range of new perverse incentives, as well as reinforcing some which existed prior to the scheme. It is these which threaten to result in differential access to both primary and secondary care for some groups of patients.

Patient selection by fundholders

Fundholders are required to pay for some major elements of the total health care used by their patients from a fixed budget. One way to respond to this requirement is to concentrate on improving the efficiency of care provided. A second way is to try to avoid costly patients, either through selecting only apparently healthy patients from those who apply to register with the practice, or through encouraging those with chronic or costly conditions to leave.

Patient selection by providers of health care

Only some of the patients on a provider's elective admission waiting list will be patients of fundholding practices. The others, who are patients of non-fundholders, will have their elective care paid for by the local health authority. Depending on the form of the contract each of these two distinct purchasers has with the provider, there is a possible incentive for providers to preferentially select patients of fundholders.

This may occur in the common situation where fundholders pay for patients on a "cost-per-case" basis while the health authority has a block contract. Towards the end of a financial year, providers may have fulfilled the requirements of the block contract, which cannot yield further income through further admissions of non-fundholder's patients. By contrast, further admissions of fundholder's patients will bring additional income.

In this situation, there is a strong incentive for providers to admit patients of fundholders in preference to those of non-fundholders. The result would be shorter waiting times for some patients, unrelated to their clinical need. It is the suggestion that this might occur which has led to the claim that fundholding has encouraged a "two tier" health service.

Setting the fundholder's budget

In addition to minimising costs, fundholders may attempt to maximise the budget which is set for the practice. To date, budgets have been set on the basis of the historical activity of the practice in the year prior to becoming a fundholder, and modified from this base in subsequent years by some locally determined multiplier.

Setting the budget in this way introduces an incentive to increase prescribing, referral activity, or both in the year prior to joining the scheme, to artificially inflate the initial budget which the practice receives. Inevitably, if some practices are able to secure budgets which are greater than those needed to care for their patients, then the resources available for the treatment of other patients must be reduced.

Under-treatment

Purchasing health care from a fixed budget also introduces the possibility that patients who might benefit from some intervention will be denied it. There is an incentive for under-treatment within primary care (since

prescribing costs are included in the fund) as well as in referral to secondary care for those procedures payable from the fund.

Cost-shifting

A further way in which the fixed fundholder's budget may be protected is to act in such a way that costs which would normally fall on that budget are paid by somebody else. There are a number of budgets to which costs might be shifted, as follows:

The health authority

If the patient can be referred to hospital as an emergency, or attends the Accident and Emergency department, then the local health authority rather than the fundholder must pay. For some conditions there may be an element of discretion on the part of the GP as to whether a patient should be referred as an elective case or as an emergency.

Patients

While the cost of very many health care activities could clearly not be shifted to users, some potentially could. The most plausible would be to encourage patients to buy those treatments which are available over-the-counter, rather than prescribe them.

Private insurers

On occasions when a patient has private health insurance and needs elective surgery, there is the possibility of referring privately and asking the patient to claim on their insurance, thus shifting the cost from the fund to the insurer.

Restraints on perversity

It should be emphasised that the points made above relate only to the *incentives* created by the fundholding scheme. While the incentives for perversity may exist, it does not follow that the various actors in the system will respond to them in this way, and for the most part it remains to be shown whether or not fundholders have in fact responded in the ways suggested. There are four main forces which may restrain such a response.

Competing incentives

Other incentives may exist which encourage action opposite to that noted above. For example, if budgets are re-calculated from time to time on the basis of historical activity, there is an incentive to maintain within-fund activity rather than minimise it.

Attenuation of incentives

Arrangements may be introduced within the system with the aim, explicitly or implicitly, of attenuating an existing perverse incentive. An example discussed above is that of the "stop loss" mechanism which would be expected to blunt the incentive to avoid high-cost patients.

Sanctions

Behaviour which is recognised as against the interests of patients or the system as a whole may be explicitly outlawed, with the threat of sanction if discovered. The early recognition that patients of fundholders may have shorter waiting times than those of non-fundholders at some trusts led to explicit instruction from the NHS Executive that admission should be on the basis of clinical need and not according to the status of the purchaser.

Ethical codes

Finally, perverse incentives may not evoke a response if actors in the system regard it as contrary to their professional ethical standards. Thus, if patient selection by fundholders does not occur, this may be because doctors believe strongly in the ideal of equality of access to primary care.

Available research on fundholding

Of the policy changes which were introduced in the 1991 reforms, the fundholding scheme has probably been the most researched feature. Despite this, little evidence is available on the question of whether the perverse incentives outlined above have turned out to have any effect in practice.

Effects of fundholding on referral, prescribing and costs

Most of the research which has been carried out to date has focused on the intended outcomes of the scheme, in terms of effects on prescribing, referral and overall costs. A number of authoritative reviews of this evidence are available.[7 8 9 10 11] Taken as a whole, the evidence suggests that prescribing costs and referrals have risen at a slower rate in fundholding practices than in non-fundholding practices.

A number of commentators have pointed out that the effect of such changes on equity, and indeed efficiency, remains unknown.[11 12 13] As with all studies of variation in medical practice, we do not know whether lower rates of treatment mean that unnecessary interventions have been reduced, or that some people have been denied needed care. It would be interesting, for example, to know whether the fall in prescribing in fundholding practices has been accompanied by an increase in spending by patients on over-the-counter drugs for minor conditions, but no study has examined this.

Patient selection by fundholders

Concern that fundholding would lead to biased patient selection on the basis of cost were expressed as soon as the scheme was announced.

Scheffler, a US health policy analyst, compared the incentives created by fundholding with those familiar from the American experience of HMOs.[14] Arguing that "adverse selection with practices at financial risk may create undesirable market incentives", he noted the difficulty of compensating for differing levels of risk, given that that biased selection of patients may be deliberate but subtle:

> If capitation payments are adjusted upwards for the elderly, then practices will be keen to attract old people who are in good health. One American HMO invited applications to its plan at a dance it sponsored for the elderly on the second floor of a building without a lift.

Anecdotal evidence

There has been some anecdotal evidence suggesting that some GPs might be responding to the incentive to remove costly patients from their lists. Such evidence has appeared mainly in the form of a trickle of press reports which followed the introduction of fundholding.[15] Surprisingly some doctors have admitted, albeit in anonymous media surveys, to removing or turning away patients they perceive as "high demand".[16] The issue has also been debated in parliament, with some MPs claiming that the number of patients being removed from doctors' lists has increased and citing examples of patients being removed for no apparent reason.[17]

Systematic evidence

In contrast to the public and media attention, there has been very little research into the question of whether systematic patient selection has actually occurred as a result of fundholding.

The "threat of cream skimming" was extensively discussed by Matsaganis and Glennerster in a study of expenditure by a single fundholding practice.[18] They identified a number of patient groups (for example, patients with diabetes, heart disease or mental illness) who would pose potentially high costs to a fund, and calculated:

> The potential financial gains from a discriminating strategy against a single patient group could be up to fifty thousand pounds. Equally lucrative could be a strategy actively seeking to register healthy individuals.

However, they did not examine whether such discrimination was, in fact, occurring.

One issue closely related to patient selection, on which some limited research does exist, is that of the forcible deregistration of patients at the request of their doctor. General practitioners' terms of service have always allowed doctors to require the relevant health authority that a patient be removed from their list, without having to give a reason.[19] Only two studies have been carried out which focus on removal from a doctor's list.

McDonald *et al* conducted a telephone survey of 89 GPs who had removed one or more patients from their list during a three month period.[20] Excluding those patients who were removed because they moved out of the area (27% of removals), the commonest reasons given for removal were "unreasonable requests for medication" (the majority of which were related to addictive drugs), "unreasonable requests for home visits", and "threatening or rude behaviour to doctors or staff".

Perry surveyed all 97 FHSAs in England and Wales, of whom 35 replied. [21] Her data suggested a modest increase in the number of removals over the period 1990-94, with removal rates per GP higher in urban than in rural areas. The data was not detailed enough to compare removal rates between fundholding and non-fundholding practices.

Perry additionally surveyed GPs in Kent to determine why a doctor might decide to deregister a patient. The commonest reasons given were violent or abusive behaviour, "inappropriate use of services", loss of trust and persistent non-compliance. Unsurprisingly, the costliness of treatment was *not* given as a possible reason.

However, research we have recently conducted in Sheffield has directly examined the possibility of biased patient selection by fundholders. [22] We examined the hospital costs associated with over 40,000 patients moving between primary care doctors in Sheffield over a two year period. Broadly speaking, the results of this work suggest that across the population as a whole, fundholders have not been systematically selecting patients

according to their costliness. However, it does seem likely that fundholders are avoiding a small number of very expensive patients. Further work is now required to discover whether particular patient groups, such as those with diabetes or coronary heart disease, are also likely to suffer adverse selection.

Patient selection by providers

Many hospital managers will admit unofficially that patients of fundholders are selected preferentially from waiting lists, for the reasons given above. However, official policy is that such "two-tierism" should not and does not occur, and no manager will admit it on the record.

However, at least two studies have now confirmed that waiting times for elective surgical admission are shorter for patients of fundholders than for patients of non-fundholders. [23 24] In addition, in Sheffield we have carried out a month-by-month analysis of the proportion of admissions to various hospitals and clinical specialties over a year which come from fundholding and non-fundholding practices. The early results of this work suggest that in some hospitals, and in some specialties, the proportion of admissions coming from fundholders rises steadily in the last 3 months of the financial year. This pattern is seen only for admissions payable by the fundholder, and not for other admissions, and is exactly the pattern one would predict from the selective incentive described above.

Budget setting

In the first years of the fundholding scheme there was much debate over whether budgets had been set fairly, with a widespread perception that fundholders were being over-resourced by comparison with patients paid for by the local health authority. Research evidence seemed to support this view, [25] although as fundholding has spread more widely and finance managers have become more sophisticated it seems likely that this initial inequality has now lessened.

Cost shifting

Again, very little evidence is available on whether cost-shifting has occurred. Because of the incentive for fundholders to send patients to hospital as emergency rather than elective cases, one study examined changes in the number of emergency and elective patients with certain surgical conditions sent to hospital in one region.[26] study found no change as a result of fundholding.

No research has examined whether costs have been shifted to users, or to private insurers. However, insurance companies have complained that the number of claims people make on their private health insurance has increased rapidly in recent years, along with the average cost of each claim.

Conclusions

There were very good reasons to suspect, at the start of the fundholding experiment, that the scheme could and would lead to systematic inequalities in access to care, unrelated to clinical or social need. Indeed, it was argued that the very fact that fundholding was commoner in affluent than poor areas made matters even worse by introducing a bias against care for those in greatest need — another example of the "inverse care law".[27]

While evidence on what actually happened is patchy and limited, many of the gloomy predictions have proved correct. Although there is not widespread or gross patient selection by GPs, there has been some effect on those with very costly conditions. It is clear that there is inequity in access to secondary care. On the present, limited, evidence cost-shifting does not seemed to have occurred, but there has been — and may still be — inequity in setting budgets for practices.

It is clear that the incentives for an unfair system exist, and that in some places, and to some extent, these have resulted in exactly that. Now, as both primary care and health care purchasing move away from fundholding to new and untested forms of organisation, it will remain as important as ever that the implications for equity in health care of whatever replaces fundholding are fully understood by policymakers, professionals and the public.

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Address for correspondence

Dr. James Munro
42, Endcliff Rise Rd.
Sheffield S11 8RU
England
Tel.: +44 114 268 2168
Fax: +44 114 266 6171
j.f.munro@sheffield.ac.uk

COMMUNITY INVOLVEMENT IN PRIMARY HEALTH CARE: A NECESSITY TO READRESS EQUITY IN HEALTH POLICY.

Alexis Benos

INTRODUCTION

In Greece the population is covered by several social insurances schemes. workers are covered by the bigger public owned insurance scheme (IKA), farmers by another (OGA), public servants have their own social security scheme, the bank employees likewise, and so on. Health care services are characterised by a gigantic hospital sector functionning in a doctor-centred, autocratic and centralised mode, overspending in high technology without any concordance with the real needs of the population. This policy has produced a cluster of hospitals services in Athens and Thessaloniki and an irrational - in relation to the population´s needs - allocation of resources enhancing mainly favouring the development of specialist and high-tech services.

The 1983 law which established the Greek National Health Service included the already-existing state-owned hospital sector and established a tax-financed network of Primary Health Care Centres in the rural areas. The plan to create urban health centres was abandoned for economic and political reasons.(1) The population of urban areas either uses hospital outpatient departments or is driven to the private sector to meet its primary care needs. The private sector has dramatically expanded in the last decade, investing mainly in high-tech services, especially diagnostic devices and procedures. This trend is a typical example of private economic parasitism as all these investments have as a prerequisite contracts with the public insurance schemes and therefore are based on public funds. This parasitic system, which has a lot of characteristics with the Italian experience,(2) is determining, to an important extent, the economic and strategic crisis of the public sector of the health services in Greece, characterised mainly by a parallel expansion of unnecessary costs and a sharp rise of unmet real needs of the population.

The main characteristics of the Greek health services are accurately descibed by JT Hart´s Inverse Care Law.(3) The prevailing middle-class mentality, intensively promoted by the media, the private insurance companies and the medical-industrial complex, promotes the expansion of a consumerism of diagnostic, curative and usually unnecessary services, leading to an explosion of iatrogenic disease which is feeding demand back into a new circle of services. This parasitic system produced a situation where Greece has the highest rate of CT scanners per inhabitant in the E.U., when still in 1994 deaths due to tetanus demonstrated partial immunization coverage of the population. Under the same socioeconomic pressures vaccination against Hepatitis B was provided to the children of middle class and white and blue collar employees, whilst social and ethnic minorities, refugees and immigrants - populations with a far higher prevalence of Hepatitis B - where excluded by a market led policy.(4)

EQUITY IN HEALTH AND EQUITY IN HEALTH CARE SERVICES

Health is determined by the socioeconomic and natural environment. Equity in health, therefore, is not feasible in a context of social inequalities.[5] This implies that health is not given and can be considered only as a social right which can be achieved not in an individual basis but as a result of social changes.[6] Stressing the existing inequalities in health and their explanation is one way to address the need for the re-emergence of social values like solidarity and societal responsibility.

Equity in health care, i.e. in the distribution of health services, implies a resource allocation that ensures equal access for equal need, equal utilization for equal need, equal quality for equal need.[7] The experience of the British National Health Service (NHS), being an important example of an effort to assure equity in health care in a national level, proves that equity in health cannot be achieved if only health care services are equitably distributed.[8]

The current widescale neoliberalist offensive is already increasing inequities in both health and health services in all European countries. Therefore, besides the goal of equity in the allocation of health services, action also needs to be taken in order to promote equity in health by eliminating the causes of ill health.

The relaunch of the Health for All strategy focusing more intensively and concretely on community involvement is an urgent need in order to build the necessary social alliances that could resist and defend health as a social right.

PRIMARY HEALTH CARE: THE NEW PARADIGM

The strategic crisis of the health services is a result of the overt epistemological crisis of the medical paradigm dominant during the 20th century. Disease-and-organ targeted, hospital-and-doctor-centred this biomedical paradigm is now under the full control of the biotechnology industry and determined by the market incentives of competition and short-term profit, enhancing over-medicalisation and over-use of high-tech interventions.[9] The emerging new paradigm of new Primary Health Care focuses on the developement of holistic and community based services responding to the real needs of the population and therefore building up public health at a local level. The British experience implementing the comprehesive coverage of all the population with locally based primary care services and introducing the gatekeeping role of the General Practitioners produced an important step forward in the period of its implementation. Neverthless it was built as (and remains) a mainly curative and disease-targeted service, doctor-centred in its functioning and excluding any community participation and involvement. Characteristics that possibly can explain, partly at least, the NHS crisis and especially the limited resistance to its dismantlement.

In order to complete the new PHC paradigm two functioning dimensions have to be implemented:

- **multidisciplinary team work,** positively replacing the autocratic and, limited in terms of effectiveness, role of the doctor- centred model, and
- **community involvement** in order to replace the consumerist model. With the help of proactive activities, information and mobilisation of the local population in order to promote participative democracy in local level.[10] Needs assessment and the decisions for the actions to be taken in local level could be a result of some kind of participative structure. The active involvement of the local community in the decision making for the local health problems is indispensable to build a resistance movement against barbarism and could be the basis for the common struggle for equity in health.

THE TRIANDRIA PRIMARY HEALTH CARE UNIT

The Triandria Primary Health Care Unit is a community based project designed with the intention to implement and develop a model of health services covering the following dimensions:

- to develop and evaluate the feasibility of a network of **primary health care services in an urban social setting** responding to the real needs of the local community.
- to promote **active community involvement in health policy**. The Unit is funded and controlled by the local authorities, an innovative situation for the Greek social setting. Another expression of community involvement is the implementation of participative structures on specific problems and interests (healthy women committee, healthy workers committee, sports and exercise, diabetics, etc).
- to shift scientific research and academic activities from their traditional "intramural" and self-serving environment towards a **developmental research assessing and responding to the real needs of the community**.
- to shift medical education from the "disinfected" hospital environment towards a **community oriented education**, i.e. the exposure to the real world, where people live, work and its ill-health is determined by their social and economic profile.
- to implement, audit and evaluate **multidisciplinary teamwork** and promote it as a realistic alternative to the historically exhausted, politically autocratic and epistemologicaly inappropriate doctor-centred paradigm.
- to provide **multidisciplinary education** at under-and postgraduate level.

Needs assessment, continuity of care, home care, community-based health promotion activities are some characteristic examples of actions taken by the multidisciplinary team that ensure solid relationships with the local population and enhance the perspective of social involvement.[11] The every day work of the Unit is reintroducing social solidarity and empowerement.

The resulting political proof that high quality primary health care services can be provided by local authorities structures is gradually producing a new set of social values and beliefs in the local community, opposing the nowdays prevailing market ideology.

Dealing with specific problems of the local community enhances the active involvement of the population in decision making. This process is leading to the development of a grassroots movement for health mobilised with concrete actions for equity and solidarity.

The experience already gained from this project is showing that community involvement in health policy is feasible and could have an important impact in building up new social alliances readressing the need for equity in health and health services provision.

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Address for correspondence

Prof. Dr. Alexis Benos
Laboratory of Hygiene and Social Medicine
Medical Dept. - Aristoteles University
P.O.Box 1689
GR-540 06 Thessaloniki
Greece
Tel.: +30 31 99 91 37
Fax: +30 31 99 97 01
benos@med.auth.gr

THE "FREEDOM OF CHOICE" IN THE HEALTH CARE SECTOR: PRIVATISATION OF THE COSTS IN THE ITALIAN CONTEXT

Lorenzo Terranova

One of the reasons of the victory of the Italian centre-left wing coalition, the *Ulivo*, in the 1996 elections was the awareness that the reform of the Welfare State could not be left to the Italian conservative and moderate forces. In Prodi's government programme (the first one including the *PDS* and backed by *Rifondazione Comunista*[1]) the launching of a Welfare State reform was one of priorities. It finally seemed that the analysis and debate on the country's decisions would be a substantial and overall review of the whole welfare system, instead of circumscribed interventions limited to a few sub-systems.

The debate on health is representative of a broader issue: the logic of the interventions during the last ten years followed exclusively a financial approach that was simply aimed towards implementing savings (by reducing expenses or increasing revenues).

This paper intends to promote considerations on how and why the aims of the Italian national health service (*SSN*) were not fulfilled or were found lacking (to an extent that *SSN* is characterised by a privatisation process), and the ensuing risks.

The left-wing's challenge in the health field is to set down proposals without incurring in the neo-liberal solutions that characterise health in Europe. I believe that the health expenses transfer from the public area to the private one may be opposed by reviewing the productive processes and especially the work process. Free traders had their work cut out for them stating that the final product can be improved by the privatisation of production, countering inefficiency. During recent years the left-wing was not ready to face this challenge and retreated into conservative positions. This approach can also be ascribed to the trade union's role that proclaimed the needs of health workers above all, and did not help the left promote citizens' new needs. To stand up efficiently to the neo-liberal position, the left has had to abandon the ideological barriers preventing it from facing work re-organisation. In fact, only the left will be able to guarantee satisfactory conditions for health workers that could otherwise not be vouched for.

"Productivity", "correspondence" and "inexpensiveness" are passwords that must take into account the so-called problem of "excess of demand": with the increase in health demand (in relation also to demographic trends) committed resources compete at a macro level with the new reallocation needs. The contrast between "financial limits" and "health rights" has to be resolved. It implies that new compatibility relations between ethics and economics, between rights and interests and between health and development, have to be defined.

It is of importance for the future, in order to reintroduce a social pact, to point out solutions that may take on both economic and ethical issues without giving up obligations towards citizenship and social justice.

It is in a health system restructuring frame that the need arises to consider the relation between ethics and economics, two values that have to become compatible. Consequently, all the reference values involved in health system evolution have to be checked:

1. the reform of the Welfare State implies passing from the principle of access equality to outcome equality, which then has to be followed by a review of the whole in terms of performance quality, its utility and its opportunity;
2. the universality principle of the national health service (*SSN*), in a quality sense, requires the utility/opportunity combination to become specific and selective;
3. a mechanism combining utility and opportunity combination implies considering the operational modes that are implicit in the equality notion; a relationship between needs and individual resources has to be defined, as territorially-based criteria are no longer sufficient;
4. a personalisation of the utility/opportunity combination implies considering the operational modes that are implicit in the equality notion; a relationship between needs and individual resources has to be defined, as territorially-based criteria are no longer sufficient;
5. outcome equality and the individual needs/resources relationship require a new funding system that has to fit into a set of safeguards guaranteeing universality and personalisation, citizenship and solidarity.

Consequently, for compatibility reasons between ethics and economics, against a framework of productivity, correspondence and inexpensiveness, the restructuring process implies:

- reviewing guarantees;
- equality of possibility;
- straightening out welfare;
- broadening individual opportunities;
- equal starting conditions.

Compatibility between ethics and economics has to have a new equality principle, a redefinition of the criteria of distributive (economics) justice (ethics).

There should no longer be an offer of welfare services available only because of legal right, but conditions should allow free choice to individuals, without resulting in unequal starting conditions.

The implications of this position are extremely interesting. At last some market forces will be less restricted by public regulation. They will be able to operate with improved efficiency and effectiveness, offering goods and services which will, however, be guaranteed by the public body.

Reconsidering equality in the health sector means going from "general universalism" to "selective universalism". This would mean a change from residual health care welfare (situation in which a series of services are offered to everyone), to market health care welfare (in which the buying power of the weak is enhanced without discouraging social consumption of others).

This does not particularly support the idea of a "minimum state" as it adds strength to the change from a system based on formal right to a system based on "substantial" right. It is not sufficient to access services, results must be obtained from accessing. It is, in fact, the passing from a universalism understood as "access equality" to one understood as "result equality". The allocation of utilities and opportunities and the process of personalisation of performances imply that a new equity would bring about a thorough restructuring of health care together with a fine tuning of fair co-payment.

Having taken into account the conceptual apparatus of analysis, a very important aspect has to be underlined. I believe it represents a fundamental preamble that has never been faced in debates by reformist political parties. With regard to privatisation of a health system, there may be two meanings (refer to tab.1 and 2):

a) transferring a series of costs which were originally shared out jointly and severally among all citizens, to those who actually sustained them;
b) changing of the contractual modalities of health operators.

In this paper the privatisation notion implies avoiding burdening some weak categories with a series of costs. Indeed, the income positions of some professional categories (I am referring to health personnel) - do not simplify the processes of health intervention. Actually, in Italy a part of the health privatisation process (meaning a shifting of costs which were once shared jointly and severally and which are now increasingly sustained by citizens) may be explained by the on-privatisation of the health care providers' work relations.

A brief history may be useful. The 1978 reform radically changed the modalities of health offer by making health services available to all. The problem that characterised this change is the failure to link the responsibility expenses (the Treasury and the Parliament) and the decisions about expenses (implemented by the Regions). In this frame, and to answer the relevant political and patronage requests, the Italian health model was characterised by the unproductiveness of the work itself, more than by the high number of *SSN* employees (and by the health providers' productivity). The core of the *SSN* problem (that was then reflected both by the financial side and by the public's appreciation) was

not to reconsider work in a dynamic way, rendering it effective and functional to citizens, more than to those working in it.

The Italian Legislative Decrees 502 and 517, approved in a new phase of State reform, ushered in a deep change. They allowed for a freedom at the margin to introduce a change in health service work. The decrees are starting points that clearly have to be supplemented with normative instruments and regional implementations. The issues tackled in the decrees are considerable ones that may be defined as:

a) aims and strategies to be adopted so that civil growth and health protection are guaranteed to the entire national community. (The planning issue);
b) power systems in health decisions. The director general's issue and the management's in particular;
c) company-like health organisation systems. (The hospital and the Local Health Unit (former *USL* now *ASL*) issue, they offer modality);
d) minimum assistance levels and health funding systems. (The financial resources issue);
e) Providers and their training. (The human resources issue).

This document will consider each of these issues. It is clear though, that the management and human resources issues are the major ones, even more so as 50% of health expenses are in those fields (refer to tab. 3).

However, setting aside the 1992/93 reform, the intervention consisted of limiting expenses by setting more or less strict ceilings. For instance, the ceiling set for medical personnel belonging to hospitals during the three year period 1994/96; the contract had expired in 1994 and was initialled only a few weeks before the 1996 elections.

Furthermore, the repeated making-good of the balance deficit (recently with the law 21/1997) clearly stresses that the ceiling control method is effective only if the collection role (funding of the system) and the expenses role are undertaken by a single actor (the Region). Actually, the first results deriving from the modified behaviour of central authorities seem to offer positive outcomes. The greater financial power of the Region through contributory incomes and road surtax) and a greater funding defined by the Parliament (the national health fund, *FSN*, which used to be a ridiculously small amount) have reduced the deficit. Do note that the general report on the country's economic situation (*"Ralazione generale sulla situazione economica del Paese"*) states that last year (1996) the balance deficit between public health expenses and its funding was of 3,134 billion of lira. Public health expenditure represents only 5.4% of the GDP, which is much lower than other E.U. countries.

Without judging the distribution of public and private health expenses, it has to be noted that the ceiling method will be inefficient unless there is an intervention in the production phase of the flow

itself. This would mean intervening on the productivity of the elements used, and mainly on the work element.

In other words, cost-containment intervention is characterised by cuts in resources, leaving productivity virtually untouched. The underlying (incorrect) hypothesis was that the secondary effect (indirect) of setting expenses ceilings would have been a productivity increase. In the Italian instance there was a reduction of available funds (amongst others, productivity funds[2]) without, however, reviewing the organisation in order to improve productivity.

The most recent data from the general report on the country's economic situation show a constant growth in staff expenses (in terms of ratio increase it is not the main cost, but it did absorb 43.2% of all the public health expenses in 1996.[3]

However, even if the ceiling setting mechanism is operative over a one or two-year period, by itself it will not tackle the productivity/growth issue because it does not influence the organisation of goods and allocation of services.

The work factor issue has then to be viewed differently.

Unproductive performances and their inappropriateness are based upon the lack of an organisational model of work, incapable of adapting to the evolution of the health care model and to the growing complexity of needs.

It has to be said that work in the health area is managed more or less at the operators' discretion (doctors, administrators, paramedics, etc.). This leads to an information asymmetry; there is no encounter on a "equal basis" between those offering health services (hospitals, surgeries and doctors) and those requesting it (citizens).

The information asymmetry issue in the health market has different meanings dependent on the model used.

There is the "agency relation model" where it is assumed that the doctor (agent or mandatory) allows for choices between various possibilities on behalf of the patient (principal or mandator). In this context the agent's utility functions may not coincide with the mandator's utility function (as it is often the case). In this case there is a situation of "second best" choice. Faced with these asymmetries, the health system reacts by setting a series of incentives/punishments for its agents (a typical example is the basic budget for GPs). The intervention is focused on the control of whoever has information and not on its greater transparency (and spreading).

At a system level, and in this case I am referring to hospitals, this relation becomes a collectivisation of the patient (mandator)/doctors (agents link. More specifically, knowledge or information is shared out jointly and severally between agents in order to stress the distance with the patient. Knowledge is not passed on to the patient; indeed it often happens that the use of technical terms and behaviours increases the doctor/patient gap. In this (team) model there is a connection between each utility function of the agent; these functions belong to the hierarchical structure, or rather to the power in the team (so the utility function of the head physician is greater than the assistants', but all the functions are compromises in perpetual balance). The health system's reaction in this case is to try and define instruments such as, for instance, DRGs that bind the agents' utility function.

However, the issue is linked to the increase in knowledge (and consequently in contractual power) of the patients in order to bind increasingly the agents.[4]

Furthermore, health (from the micro level to the macro one) is managed at the providers' discretion (doctors, administrators, paramedics, etc.). Most of the work is carried out by operators in a frame in which the demand does not meet the logic of a competitive market.

It is in this frame that there is a daily confrontation between users (who request services) and operators (who offer them), expressed as a difference between what should be done (on the basis of bonds that are mainly normative ones) and what is done (to meet the requests). This asymmetry is absorbed by the health provider who has to set modalities of provision that meet the citizen's requests in quite a strict normative and contractual context. It is during this phase that there is a productivity loss, both of the work factor and of other productive factors. For instance, should there be a relevant mechanisation of laboratory work, in order to have an efficient and quasi-continuous work cycle, workers ought to operate all day. This would imply a diversified use of their time and activities. The health provider takes on the difference as he has to give concrete answers to the citizen's requests, in a context set by regulations or by a strict contractuality. How can this lack of co-ordination, that breeds the citizen's discontent towards the *SSN* be overcome?[5]

I believe there are two options (that do not contrast):

a) decentralise work government;
b) promote interventions by new actors (for instance, a new definition of the role of local bodies) capable of spurring behaviours adapted to the specificity of the operational reality, reducing the organisational habits established by the centre.

On the whole, a stock of minimum rules set by the centre has to be picked out and organisational models - meeting and defending the specific needs of the structure[6] - ought to be experimentally grafted onto them. It actually would mean leaving intact the tayloristic model within the health system (with professional profiles, job descriptions, etc.).

This would result in a different responsibility of the worker; the provider would actually undertake some functions which are currently carried out by the organisation.

The above implies both a restructuration of the wage system and of the flexibility of the work tasks:

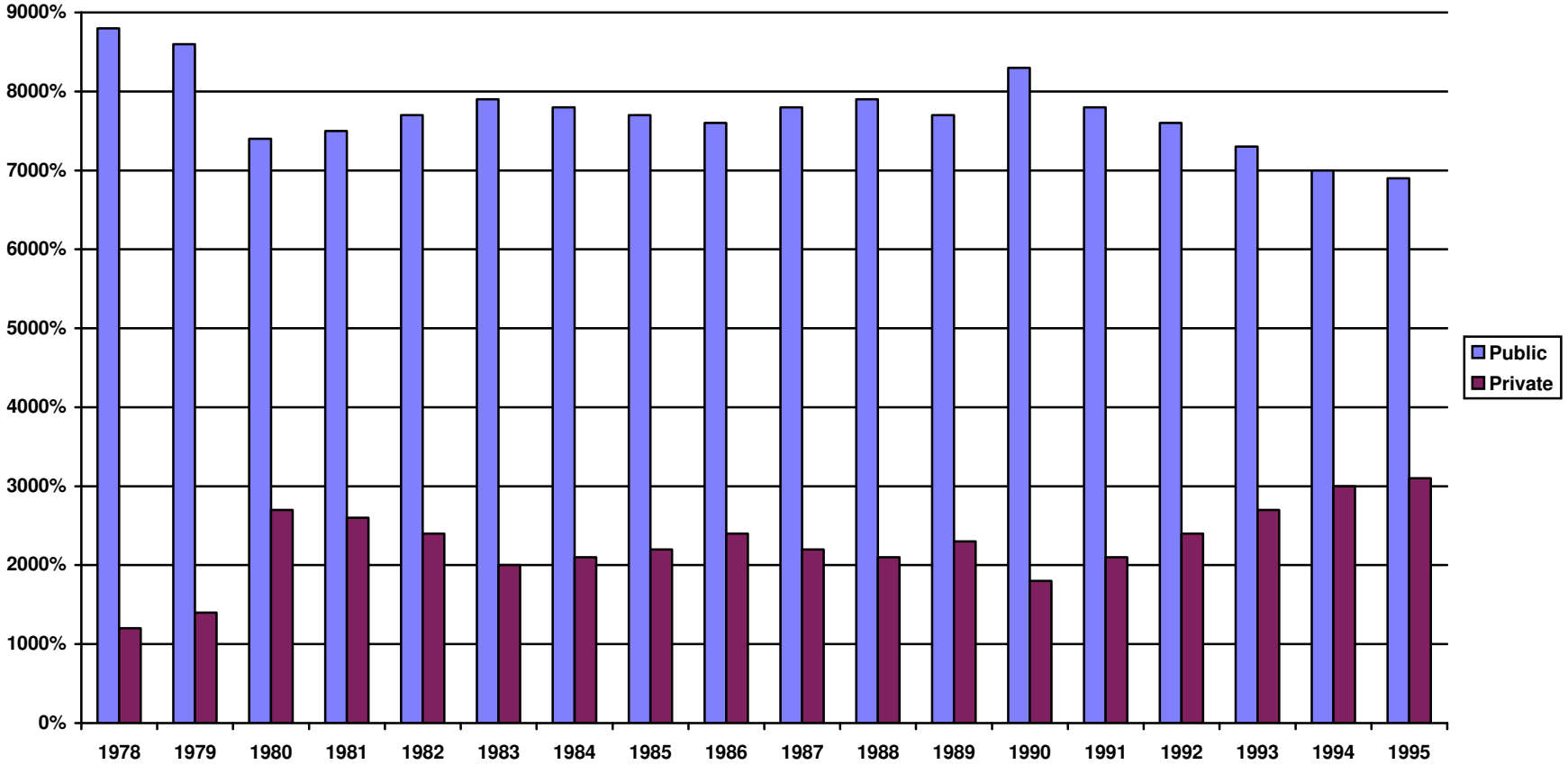
- it is necessary to pass from a salary conception that is mostly independent from what is actually done, to a salary related to results;
- all payment systems that are independent from work (*per capita* payment, by the hour payment, integrated salary scheme) have to be replaced;
- the guaranteed minimum salary rate has to be reduced, balancing it against an ever-growing salary to be defined with the service, and decentralising therefore growing rates of variable wages;
- the regulation system superintending the professional salary framework has to be restructured;
  The professional profile may only be a reference scheme describing the minimum qualifications needed to carry out specific tasks. At the same time it has to have a wide mesh that encourages professional versatility, functional mobility, integrated interdiscipline, department and district separation of work;
- It is suggested the reference professional profile should be placed with an "operational protocol", applying the profile in well-defined organised contexts, in relation to clear aims and together with specific compensation forms;
- work relation must absolutely be redefined, it has to relate to flexible budgets and to the role of the collective contract, which also has to be reviewed by coupling it with proper individual contracts similar to company ones, supported by an efficient incentive system;
- in the event of experimental self-governing management of services, the relevant rules defining compensation have to be set;
- the turnover freeze is an operational instrument; mobility from the hospital to the community must be encouraged.

It is only by serious consideration on work that important health reforms can be set up, that do not damage the citizen and do not involve a simple shift of costs to families.

Address for correspondence

Dr. Lorenzo Terranova
Farmindustria
Piazza di Pietra 34
I-00187 Rom
Italy
Tel.: +390 6 67580703 direct-+39 6 675801 switchboard
Fax: +390 6 6786494
farmindustria@mclink.it write: to the attention to Terranova

Public and private expenditure in the health care sector



A CRITICAL VIEW OF GLOBAL BUDGETING IN GERMANY'S SOCIAL HEALTH INSURANCE SYSTEM

Hagen Kühn

Introduction

I once suggested that some form of budgeting would be politically unavoidable in Germany's social health insurance system. Within the framework of this assumption I am now arguing against global budgeting in the form of prospective stipulation of the maximum contribution rate and am instead advocating a flexible budget that is not designed for the short term but the medium term, is not global but specific to fractions of the system and regions, and is oriented to needs and results. Such a budget – if thoroughly integrated - would be an expression of health and social policy responsibility on the part of a democratic state.

For brevity's sake I would like to point out a number of unintentional consequences inherent in the form of global budgeting through "contribution-rate stability".

Global budgeting: "stability of contribution rates"

Among the many possible forms of 'budgeting' in the health system, the principle of 'contribution rate stability' is anchored in law in Germany, although it has never yet been strictly realized. It states that the financial volume of the social health insurance system is permitted to rise together with the wages on which contributions are imposed. In rough terms that means: the growth of expenditures must be adjusted to the growth of the contributory payroll total.

Legitimation ("cost explosion"?)

Let us take a brief look at the empirical knowledge we have about the expenditures or "costs" of the social health insurance system: as table 1 shows, the percentage of the gross national product spent by Germans on the health system (HS) or social health insurance (SHI) has remained nearly constant since the end of the 70s. If five-year averages are taken, because of cyclical fluctuations, the result is that while an average of 5.74% of the GNP was spent on SHI between 1975 and 1980, it was 5.73% in the five years from 1989 to 1993. In that case, why all the excitement?

The excitement - which, by the way, stems less from the insured persons than from employers and economics professors - is due to rising contribution rates. The annual average contribution rate for SHI rose from 8.2% in 1970 to 11.4% (1980) and 13.41% in 1993. The contribution rates fluctuate with the economic cycle in as much as the revenues have periodically deteriorated in proportion to the expenditures, which then provokes a respective cost-control act as the government reaction. The *dynamics* thus clearly originate on the revenues side.

How can the contribution rates rise, however, when the percentage of social wealth spent on the health system remains constant? Only in as much as the revenues drop:

Table 1: Share of the national income from dependent work (wages and salaries); Expenditures of medical care and of the social health insurance system as percentages of the gross national product, (former West Germany)

Year	ANQ (1)	BLQ (2)	BBLQ (3)	BNLQ (4)	GW (5)	GKV (6)
1960	77,0	60,1	65,0	47,3	-	-
1970	83,4	68,0	68,0	45,0	-	3,53
1975	86,0	74,2	71,9	43,8	-	5,66
1980	88,3	75,8	71,6	41,2	8,4	5,82
1981	88,4	76,8	72,4	42,3	-	5,99
1982	88,4	76,9	72,5	42,2	-	5,83
1983	88,4	74,6	70,4	40,2	-	5,72
1984	88,4	73,4	69,2	38,9	-	5,67
1985	88,7	73,0	68,6	38,2	8,7	5,93
1986	88,6	72,1	67,8	37,8	8,6	5,89
1987	88,8	72,6	68,1	37,6	8,7	5,94
1988	89,0	71,5	67,0	37,1	8,8	6,07
1989	89,1	70,3	65,8	36,1	8,3	5,69
1990	89,4	69,6	64,9	36,6	8,3	5,48
1991	89,5	69,6	64,8	35,5	8,4	5,68
1992	89,6	70,7*	65,8*	35,4*	8,7	5,95
1993	89,4	72,1*	67,2*	36,1*	-	5,84*

(1) ANQ: Percentage of employees among persons in gainful employment
(2) BLQ: Share of the national income from dependent work (wages and salaries) (including 'employers actual and imputed social contributions')
(3) BBRQ: labor's adjusted gross share, ANQ = 1970
(4) BNLQ: labor's adjusted net share (BLQ without wage taxes and employee's actual social contributions but including 'employers actual and imputed social contributions') ANQ = 1970 (5) Health system expenditure as a percentage of gross national product (GNP)
(6) GKV: Social health insurance system's expenditures as a percentage of GNP

Sources: Eigene Berechnung n. (1)-(4):Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung 1994/95, BT-Drucksache 13/26, p.345, 353; (5) Schieber, G.J./ Poullier, J.-P./ Greenwald, L.M.: Health System Performance in OECD Countries, Health Affairs, Fall 1994, p.101; (6) Sachverständigenrat der Konzertierten Aktion im Gesundheitswesen, 1994, p.309

From table 1 it can be seen that the share of the national income[1] from dependent work, i.e. wages and salaries, has declined since the end of the 70s, with the 'income from entrepreneurial activities and assets' increasing correspondingly thereto.

Only during economic downturns is the chronologically delayed drop in wages briefly expressed in a rising share. Compared with the average of 1975/80, the gross share accounted for by wages dropped by the quinquennium of 1989/93 from 75% to 70.46% of the national income. If the contemporary higher percentage of

employees among persons in gainful employment is taken into account with 'labor's adjusted gross share', the share of the national income accounted for by wages dropped from 71.75 to 65.7%. The deterioration of the employees' distribution situation is expressed even more clearly by labor's adjusted net share: it dropped from 42.5% (1975/80) to 35.9% (1989/93).

But where are the "additional" wage costs ("Lohn-Nebenkosten"), the heart of the legitimation for a restrictive policy? Is it really the case that they "eat up" this wage trend so welcome to the companies, thus invalidating it? To answer this question it would be sufficient for the experts and journalists who suggest this every day to risk a look at the fine print in the statistics. There it can be read that the "employers' actual and imputed social contributions" are contained in the - declining! - gross share accounted for by wages (and even in the net share).[2] The Federal Government also overlooks this in its "Industrial Location Report" ("Standortbericht") and adds the employers' contributions to the wage costs a second time.[3] Now, since the SHI is financed entirely from these contributions, *there are, literally, no "additionals" any more in the gross payroll amount, the percentage of which is definitely not tending to rise but is declining*.

Result: while the percentage of the GNP accounted for by SHI has remained unchanged since 1975/80, the share of wages and salaries in the national income has dropped. If, therefore, the employment figures and labor's share had remained constant from the 80s until now, today's contribution rate would correspond exactly to that of 1980. To put it another way: if the percentage of the national product accounted for by wages had risen, given the empirical trend in expenditures (i.e. the given 'cost explosion'!), the contribution rate would even have *fallen*. Thus, with the seemingly neutral linkage of financing to wage developments, fundamental decisions are in fact made that might not even be intended by many participants.

What is decided with the precept of contribution stability?

Very few of the people involved are aware of what social relationships and economic developments the medical and nursing care is linked to by this precept.[4] The main implications are the following:

First: the coupling of state expenditures to "objectively" specified economic data is a method by which the financing is removed from democratic decision-making processes and controls.

Second: the ostensible objectification of the mechanical link with the political economics of income distribution also conceals the fact that with such a method the extent and, in some respects, the quality of social-state services is even formally decoupled from social-policy objectives.

Third: the total payroll (table 1), from which the contributions can be collected, is, in the end, the product of the wage level and the employment rate. Their level and growth therefore depend on the politico-economic *balance of power* between labor and capital or public employers and, to double extent, on the *labor market*. For one,

because falling employment rates directly reduce the total payroll and, for another, because the workforce "surplus" is the central mechanism with which a weakening of the labor unions and a relative lowering of the wage level "are pushed through" in industrialized market societies. The seemingly so objective principle of contribution rate stability now imposes market and power mechanisms on the wage components which are redistributed to the social health insurance system.

Fourth: In every western industrialized country, and thus in Germany as well, it is above all the labor market, as the buyers' market, which indicates that the trend in the direction of a lower wage and salary ratio will continue. Society's largest service sector (i.e. wage-intensive, lower-than-average productivity) is tied to a declining macroeconomic variable.

Fifth: once this context has been fixed in place and legitimized, all the control media inside the health system, i.e. the market, the legal system, professional norms and expertise, are used in such a way that they become transformation mechanisms which see to it that the macroeconomic imperative is also implemented by the institutional decisions made in the doctor's practice and hospital, i.e. executed within the doctor-patient-relationship. The more the patient innocently trusts that the physician will be acting as his agent and not as the agent of the institution and its "bottom-line", or of the state or a future generation[5], the smoother this takes place. This individual chance to find the help of a loyal doctor in the case of need is an individual opportunity for everyone, a "public good" which is at stake here.

Finally - sixth - it is also necessary to point out a rarely noted property of budgeting strategies, the fact that they promote the 'monetary illusion'. That is to say, the flow of money and the control thereof is taken for the thing itself and replaces efforts to solve the real structural problems of health care. The budgeting ('capping') of doctors' fees, in which an undesirable expansion of volume beyond the specified growth rate (e.g. the revenues) is compensated for by a decline in point values for individual services, is exemplary of this illusion. Thus, for example, the expansion of volume in a panel doctor's district within a period of four years' time can lead to a point-value decline of 40%. The physicians have the same collective income they would have had without the expansion of volume. The "costs problem" therefore only appears to have been solved, for the resources (e.g. 40 percent, i.e. two out of 5 weekdays of the doctor's working time) were used up in real terms and are therefore no longer available for any alternative or more beneficial use. They simply were not paid by the insurance institutions but by the suppliers themselves.

Personal services

The personal and patient-related services with far above-average labor- and wage-intensity are a dilemma. Budgeting that is oriented in the long run to an unchanging percentage of the national product (or even to a declining wage and salary ratio) must entail in this case - i.e. in precisely those communicative types of services to be promoted - not stagnation but restraint.

Example: there are hardly any goods that can be compared with each other over an extended period of time. Let us therefore take an egg, as an agro-industrial product, and a man's haircut (MH), as a personal service. After the Federal Republic was formed, an egg probably cost about DM 0.20 and a MH about DM 2.50. If we take the DM of 1950 as being worth DM 0.25 today, then an egg at today's price of DM 0.40 cost DM 0.10 in the DM of 1950. In real terms it is thus about fifty percent cheaper. The MH costs DM 25.00 today and has become about 2.5 times more expensive. Thus, while a personal service cost 12.5 eggs in 1950, it costs 62.5 eggs today. The price ratio between the material product and the service has changed from 1 : 12.5 to 1 : 62.5. Let us assume an individual consumed five eggs a week in 1950 and went to the barber every two weeks. If this had been updated with the average inflation rate, today's budget would permit consumption of twice the number of eggs (40 instead of 20). But the trip to the barber would only be possible every five months instead of twice a month. The barbers would either lose (in real terms) four-fifths of their 1950 income or their number would have dropped to 20 percent. The egg producers could employ just as many workers with double the productivity.

Conclusion

Only a few conclusions can be hinted at. In the given conditions it is important to find compromises between orientation to health, social and ethical needs and the imperatives of the dominant political economy. That speaks against global budgeting (e.g. via a prospective setting of the maximum contribution rate) and for flexible budgeting that is not designed for the short term but the medium term, not global but specific to sections of the health care system and regions (but thoroughly integrated).

The extent and profile of the financing should be a distinct expression of the will that goes into the formulation of health policy, i.e. the result of transparent democratic decisions and not a schematic coupling of the financial latitude to macroeconomic parameters ("contribution rate stability"), which have nothing to do with the requirements of health and social policies.
On the condition that inflation resulting from power-related prices and inefficiency can be kept as small as possible, a rising percentage of expenditures for socially desirable, personal services would be a downright positive expression of the overall economy's growth in productivity. For, the mass of material goods can be produced by an ever smaller work force due to constantly growing productivity. The economic *precondition* for expanding and improving the social-service sectors would also lie precisely in the growth of industrial productivity, which today finds its ominous expression in, above all, mass unemployment and a surplus of material objects (e.g. waste). Since this applies to equal extent to all industrialized countries, the argument of the world market competition is especially superfluous.

A budget should not be linked to the short-term development of growth and distribution but should be *need-related* (i.e. apportionment of differing amounts of resources to individual sectors in accordance with health-policy criteria), designed for the *medium term* and slightly *higher than the growth curve of the GNP*. A certain *regionalization* would likewise be advisable, but only if the regional financial volume is not tied to the economic

wealth of the region. Not only the macro-control by way of budgeting but also the economic and institutional microconditions have to leave room for the *extraeconomic dimensions, i.e. the health, cultural and moral dimensions,* of the health care system. This is precluded by the transformation of public service institutions into enterprises acting on the narrow-minded basis of its "bottom line". Moreover, these cultural and ethical dimensions are at risk, if those enterprises are subjected to the financial pressure of a global budget that is also oriented to a wage and salary share with a falling tendency in the foreseable future. Not only that. Even if the catalogue of SHI services remains completely intact, it is likely that the principle of solidarity will erode at the level of the services rendered.[6]

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Address for correspondence

PD Dr. Hagen Kühn
Wissenschaftszentrum Berlin
Reichpietschufer 50
D-10785 Berlin
Germany
Tel .: +49 30 25491579
Fax.: +49 30 25491684
kuehn@medea.wz-berlin.de

SOLIDARITY IN THE STATUTORY HEALTH INSURANCE

Walter Baumann

This paper reviews the scientific and political debate in Germany concerning benefits supplied by the statutory health insurance which are suspected to lack the so-called 'insurance-relationship'. The issue is addressed with special attention to the health care system, but it could be addressed in the same way for other branches of German social security organised through social insurance systems.

All countries in Europe, whatever their systems of social security, face an ongoing rise in health expenditures. Tax-financed health systems as well as contribution-based systems are constantly looking for new funding sources to meet the financial burden. In Germany today the politically-preferred solution of raising new funds is to increase co-payments in the statutory health insurance.

However, increasingly our European neighbours do not base their financial resources for health care only upon contributions to health insurance systems. For example, in 1995 Spain assigned a certain amount of sales taxes to social security. The increase of value added tax was matched by a reduction in contribution rates. In a similar way Portugal has balanced its social insurance system.

For some years now France has tapped new financial sources for health care by taxation, namely a tax on alcohol, one on advertising expenditures of the pharmaceutical industry, and others. Furthermore France has introduced the "contribution sociale generalisé", a kind of social-insurance-tax, which has to be paid on all forms of income, including investment profits.

All in all, we see many attempts in many countries to find a new balance in health care between public responsibilities, which are tax financed, social insurance systems and private care. There must be some good reasons to enlarge the tax-burden for financing social goods and services. Demographic changes, current mass-unemployment and the apparently uncontrollable growth in demand and supply of health services all stress on the question, how to raise funds and how to bear the financial burden?

TAX:	One-side obligation of payment without entitlement in return
CONTRIBUTION TO SOCIAL INSURANCE:	Obligation of payment with general entitlement to services in return
PRIVATE INSURANCE PREMIUM:	Voluntary payment with definite counterpart in return

German politicians have recognised the impact of health expenditures on occupation. The health market is a growing market and therefore policies may not be suitable which focus simply on cost-containment in health

care. That is why German politicians have changed their point of view during the last few months quite radically. The problems of control in the health care system, which seemed to be problems of cost and efficiency, have been redefined as problems of a sufficient revenue for health care. The main target is no longer higher efficiency in health care to make its costs tolerable, but improving its financial basis without a change in quality and structure of health care providers.

There is a central dogma in German politics which is emphasised by nearly all political parties: the price of labour and capital may not be raised. To shift additional resources from private income into the health care system has therefore to be recognised as the main political objective. In this regard raising contributions to the social health insurance is perceived as making labour more expensive and therefore to set false economic incentives. In this situation it is quite astonishing that the German government rejects all proposals to tap private income by additional taxation. Obviously the government is afraid of a growing middle-class-opposition against new tax-burdens which are believed to affect economic activities negatively.

THE GERMAN SOCIAL INSURANCE SCEME

INSURANCE CONDITIONS

> contribution rate ~ 13,5 % up to a renumeration
  of 6150 DM per month (assessment ceiling)
  to bear half/half by employee/employer
> no additional contribution for co-insured dependants

SUPPLIED BENEFITS

> health goods and services
> monetary benefits (sickness allowance)

In this state of affairs the number of influential people who demand a shift in financing insurance benefits from contribution to taxes has been growing. These demands are supported by all political colours, from left to right. First of all they emphasise the question what kind of benefits supplied by the statutory insurance systems should be financed by contributions, according to systematic criteria. It has been widely argued recently that various benefits lack any relationship whatsoever to insurance principles in the social insurance system. That is why, that these extraneous benefits have to be taken out of contribution-financed systems and be replaced by social goods supplied by public administration.

The more left voices hope that the shift supports a mobilisation of additional public revenue for social security. On the one hand, social-democratic positions and forces for the insurance systems find themselves acting to

stabilise these systems. One the other hand, the conservatives count on the effect that some social benefits are removed without replacement, by this approach. Of course, the national budgets are in no way able to take over social duties corresponding to the amount of costs in question. The conservative target is in fact the neoliberal cure of a lean social security system.

The issue of the benefits which are said to be not insurance related is based on the view that the government has followed political strategies of social reform using the social insurance systems and their contribution funds as instruments. It is argued that the government has used the social insurance system to perform public duties. In this view, the current problems in financing seem to be introduced into the social insurance systems from outside. The insurance systems were forced to bear social burdens which do not fit their genuine function. Consequently, all critics despite their political colour agree that it might be decided systematically which social goods have to be supplied by insurance funds and which do not.

If you look at the benefits which are blamed for a lack of insurance relationship you find first of all those very closely aimed at the redistribution of wealth. It is a central objective of the statutory insurance system to facilitate social security for the less fortunate part of the population by burdening the more powerful shoulders with costs. From my point of view the principle of solidarity is the principle of redistribution of wealth. I would like to stress the point that solidarity does not mean risk compensation in the way every insurance is operating.

In view of critics of social insurance systems, the redistribution of wealth has to be kept as a public obligation. There should be no separate statutory institution serving redistribution of wealth within the group of the insured. That is why these critics deny a specified function of solidarity within the social insurance system. They reject the idea that any ties of solidarity amongst the wage and salary earners should be created by insurance systems established as statutory institutions. In the above mentioned sense of redistribution, solidarity is defined as a fundamental national duty which has to include the whole society.

Looking for criteria which typify the lack of insurance relationship in a very strict sense, you find yourself irritated very soon. It is not possible to select one benefit from others by obvious criteria. Even those who support this approach have to admit that the differences pointed out are quite arbitrary, although generally they believe that only insurance dealing with the current risk compensation can be regarded as a real insurance. In this strict sense the German statutory health insurance is evidently no kind of insurance. Nevertheless, the community of the insured compensates individual risks by bearing them collectively - and here there is no difference from private risk insurance funds, revealing the common historical origins of both. The statutory insurance system, however, does not create any equivalence of individually paid contributions and distributed benefits in favour of insured or risks. There is no contribution age grading, and no differentiation between males and females. The strongest characteristic of the statutory insurance system is the immediate and common bearing of expenditures without accumulation of capital. All receipts have to be transformed into expenditures immediately.

PUBLIC BENEFITS:	· financed by taxes (public budget) · direct control of politics · depending on budget situation · all citizens are entitled to claim benefits
BENEFITS OF SOCIAL INSURANCE:	· financed by contributions (separate budget) · control of politics moderated by autonomous administrative board · insured are entitled to claim benefits

Considering the statutory insurance schemes in their historical framework, benefits which are defined as insurance related can be found from the beginning of the nineteenth century. The benefits that are now blamed nearly all constitute the birth certificate of this great achievement in social politics. In this regard, the social insurance funds have always been used as instruments of social policy in Germany. The political intention of the various governments and its political power have succeeded in turning social duties into social insurance duties. No more legitimatisation has been necessary.

This is the reason why, nowadays, the range of social insurance benefits seems to be arbitrary. However, it cannot be criticised without affecting the total statutory insurance system. Benefits of social insurance schemes represent, economically, merit goods. The recipients of these benefits are forced to join these insurance schemes, they are not able to shape their individual scope of available benefits and covered risks.

The principle of the social insurance system is characterised by aspects of social assistance which have become more and more significant in the last decade. The availability of insurance benefits has been gradually disconnected from preceding insurance and contributions obligations. These obligations no longer strictly define access, and do not determine the amount of available benefits.

In statutory health insurance, it is the loss of significance which hits the so-called monetary benefits, especially the sickness allowance, compared to goods and services in health care. Monetary benefits are bound to previously paid contributions. Health goods and services in the health insurance scheme are available for every covered person regardless of different contribution payments or periods. Therefore, health services and goods produce a stronger redistribution effect than monetary benefits.

Furthermore the conditions for the availability of goods and services supplied by the social health insurance have been facilitated and extended in the last decades. The access to benefits in social insurance funds has been widely enlarged, whilst insurance period and amount of contribution have lost their functions as barriers to benefits. On the one hand, more and more people have been entitled to claim benefits of the social health insurance. On the other hand contribution payment obligations have been kept in narrow limits.

Redistribution effects taking place within the social insurance system are no longer bound to a more or less homogeneous group, who bear the contributions and take the benefits. From this point of view - and only from this - it is correct to claim that some benefits are not insurance related within the statutory insurance system. But the number of such benefits is much lower than the range discussed before.

BENEFITS WHICH ARE CRITICISED

> no contribution for co insured dependants

> benefits in case of pregnancy and maternity

> monetary payment in case of death

> benefits for birth control and contraception

> benefits in case of legal abortion

> domestic help

There is a connecting problem. It becomes more and more difficult to estimate the effects and the direction of redistribution. One is no more able to explain clearly, who receives solidarity from whom. It has to be assumed - for it can be proved - that the more wealthy groups of insured are subsidised by the less wealthy. But the fact that redistribution does not work as it was initially intended, is no argument against redistribution in the social insurance system in general.

The social insurance scheme is losing legitimacy in the public eye. Solidarity within the system is no longer clearly noticed by those who shall participate in it. There is the risk of a decline in solidarity as a central issue in the social insurance system. The trust in and the ties of the clients to the autonomous insurance funds are weakening. These connections to the clients have worked quite successfully up to now. If they fail to work, the risks for the future and their stability of social insurance systems will increase.

In summary: From my point of view, there is no basis for talking about benefits which lack insurance relationship within a social insurance system. They simply do not exist, because a statutory insurance systems does not work like a private risk insurance. Even when done with best intention, the demand to remove benefits from this system no way supports the struggle for a new balance in the financing of social insurance systems. Rather, it destroys its fundamental principles.

Address for correspondence

Dr. Walter Baumann
Techniker Krankenkasse
Landesvertretung Hessen
Mörfelder Landstr. 45
60598 Frankfurt a.M.
Germany
Tel.:+49 69 962191-0

MODELLING HEALTH CARE REFORMS IN FORMER SOCIALIST COUNTRIES

Rolf Rosenbrock

Introduction and Methods

My personal background in respect to the topic is the fact that after some 20 years of research and policy advice regarding the framing, institution building, steering and financing of prevention, health care and social security in well-off industrialised countries I was given the opportunity to conduct five short studies in Baltic and central Asian countries in the course of the last two years. These short studies involved not only the analysis of far more than 100 interviews with experts and actors but also the organisation, attendance at and observation of seminars. The studies applied to the situation and development of health policy in the countries as well as to the forms and effectiveness of international cooperation in this area.

Two questions therefore suggest themselves:

1. To what extent are the models, behavioural expectations and mixture of regulations stemming from functioning health-care and financing systems in the west applicable to the cultural, political and economic conditions of the formerly Leninist/socialist countries?

2. What fostering and impeding roles are played by different forms of international technical cooperation in the development of independent and purposeful health policy in the partner countries?

Results

To answer this question it is necessary to take a short look at the initial health-policy situations. Until the end of the Soviet Union in 1991 these countries had a well-developed health-care system in terms of institutions and personnel, a system that provided, all in all, ubiquitous, population-wide, free and indiscriminate access to all available health-care services far above the global average.(1) The system was planned, financed and steered in centralised fashion. The control mechanisms favoured quantitative over qualitative growth. Priority orientation to the meeting of formal targets instead of producing results led at every stage of administration and health care to a tendency to inefficiency. Furthermore, these mechanisms also led to over-medicalisation due to an excessive consolidation of specialist over general care and inpatient over outpatient treatment. By today's standards the care was too physician-centred: the relationship with the patients was one based more on paternalism than partnership, and nursing had not yet emancipated itself from its role as a medical assistant's profession. Social workers and public health nurses were virtually unknown. Public health and prevention followed - in very strong institutional terms - a paradigm restricted to safety and technical hygiene. Enlightenment and health education followed what tended to be traditional pedagogical concepts. There could hardly be any talk of implementation of the WHO declarations, above all the Ottawa Charter on health promotion, that were supported basically in state-centralised declamatory fashion.(2)

The first five years of independence brought these countries not only their dramatic economic crises, the depth of which was unforeseen by the public, but also a massive decline in health, with a drop in the average life expectancy of as much as one and a half years.[3] The main reasons for this are the precipitate fall of broad sectors of the population into unprecedented unemployment and poverty, the decay of social cohesion and perspectives, the rapid expansion of material and social inequality, the increase in legal and illegal drugs as well as accidents, suicides and violent crime. Even the best health policy can compensate for this stark deterioration of an epidemiological effective balance of risks and resources to only a slight but, on the other hand, not inconsiderable degree.

The medical-care system of these countries functions astoundingly well despite the often month-long absence of state funds for the payment of the very low salaries as well as for materials and repairs, and despite the collapse of formerly obligatory continuing education. Professionalism and professional moral are usually very marked. Largely unsolved are problems involving import controls, approval and pricing as well as eradication of the black market for drugs. The feldsher stations that in terms of their approach were very suitable for primary health care in the countryside are presently disappearing, probably irrevocably: they are the last link in the still primarily centrally organised financing chain. Physicians who have become unemployed due to the incipient but usually dawdling reduction of capacities in the upper tiers of medical-care are pushing into this health-care stage All in all, the health-care system will have to make do with, in most cases, a maximum of one-third of the resources it used to be accustomed to, while, however, continuing to meet in full its obligations to the overall population - as prescribed by the constitution, laws and professional ethics. To put it briefly: the formerly socialist countries are facing the complex task of maintaining, on a population-wide basis, a physician-centred, top-heavy and inefficiently steered health-care system with too much capacity within a dramatically shrunken framework of resources while modernising it at the same time from the bottom up. That is indeed a titanic task for the performance of which there are no historic models.[4]

As regards the goal, it is possible to see, despite many national differences, a core stock of common conceptions that come down to a combination of system components viewed as exemplary all over the world and which - with a few adjustments - are compatible with each other: reorientation of outpatient care to primary health-care structures, with special attention being paid to family medicine and professional nursing, aims at implementation of the WHO declaration of Alma Ata (1977) and thus, more or less, at an adoption of concepts from, above all, Great Britain (general practitioners), Scandinavia and the USA (professional nursing). Plans for the development of a system of prevention and health promotion are oriented to WHO principles and the worldwide attempts at their implementation and institutionalisation. Models are seen above all in Canada and Scandinavia. A selective reduction in differentiation of medical-care capacities in, primarily, the inpatient sector can fall back on models - with a less dramatic history - in numerous industrialised countries in the eighties. The computerised mapping of illness, medical-care and financing events as a steering tool has produced the greatest abundance of positive and negative experiences in the USA. Debates about and experiments with efficiency-promoting incentive systems are to be found all over the world, the most advance and successful ones presumably in Canada and Scandinavia. The development of sources and administrative forms of financing outside the centralised state tax budgets, but also over and beyond private maximisation strategies via the market, can fall back on central European experiences. German experience is especially in demand here, because most of the

transformation countries are programmatically pursuing the idea of statutory health insurance and are also calling for elements of co-determination on the part of social forces (capital and labour).[5]

Conclusion

In the perspective of these concepts lies the creation of a modern, efficient, learn and affordable system for the social management of health risks prior to and after their occurrence. Knowledge of the professional, technical and qualificatory conditions for the creation and steering of these system components as well as knowledge of their desirable and undesirable effects is available internationally and can be mobilised by international cooperation. The central problem therefore lies - as is usual in politics - less in the finding of concepts and the specification of goals than in the question of how movement in the direction of the desired target situation can be organised starting from the current state of affairs. On the basis of my observations both the national actors and international consultants regularly make several fundamental miscalculations in respect to fostering and impeding conditions for the desired developments. The lasting success of reform efforts will depend on the correction of these miscalculations.

Central deficits in the transformation countries, their governments and administrations are, above all:

- Broad sectors of the population as well as many health-care professionals, administrators and decision-makers lack a basic understanding of social and health policy in differentiated and pluralistic societies. In the areas of qualification and social marketing it is therefore necessary to impart to greater extent concepts of risk-pooling, risk-sharing, risk-compensation, institutionalised solidarity and institutionalised solidarity and institutional division of tasks.

- A problem that goes beyond the area of health policy is how to impart concepts and practical knowledge of client and outcome orientation in contrast to handed-down concepts centred on the meeting of formal targets. In some cases that will involve years of learning processes that cannot be mastered in a few seminars but only as a long-term task. [6]

- The health system in the Soviet Union was officially steered with the tools of qualification, moral suasion, professional reputation and material incentives for the meeting of formal targets. Informally, political conformism was also honoured, and there was everyday corruption.[7] The development and implementation of new mixtures of moral and material incentives for orientation to health-related results are required.[4]

- The political and ideological turnabout has led to deep insecurity on the part of the health-policy actors. Officially, nearly all the tools of state control and administration have been discredited, and complementary thereto the appropriateness and efficacy of private and primarily market-controlled incentive systems are overestimated.[8,9] Unofficially, many decision-makers have a deep distrust of non-state control. This

ambiguity can only be overcome with careful and unprejudiced qualification in respect to both the desirable and undesirable effects of state, parastate, mixed and private-enterprise systems of control and incentive.

- The development and pursuance of strategic orientation and objectives with long-term effectiveness have to take place in the transformation countries at the same time as daily crisis management. It is often extremely difficult to reconcile the different logics and time horizons of these two task areas with each other so that, on the one hand, they can respectively dealt with as relatively independent entities while, on the other, keeping crisis management from being handled with tools that would block the developments desired in the long term.

- There are often considerable reservations about applying models for the control and financing of health care, e.g. by way of social insurance patterned on the German system, because this model is felt to be unattainably differentiated, perfect and expensive. In this conjunction the fact is overlooked that Bismarck's model was likewise introduced in times of severe economic crisis against the resistance of physicians and the insured parties, and initially only as partial insurance against illness-related loss of pay. (10) Knowledge of social and political processes(11) as well as the setting of strategic courses for the introduction and development of new models and institutions of social security are therefore essential for decision-makers in transformation countries.

- The poverty of broad sectors of the population as well as considerable shortcomings in the control of taxes and contributions make it impossible to completely convert, in the short term, the health-care system to financing by contributions from the insured parties and enterprises. On the other hand, independence of the financing from the state budget and the inclusion of enterprises and insured persons as the financiers and parties responsible for health and social policy are important goals. Approaches in which are initially small but, in terms of perspective, growing part of the expenses are financed by contributions, the state budget being accordingly relieved, would appear to be promising.

- Concepts involving partial privatisation of the financing of and responsibility for health care regularly envisage a transfer of important functions to representatives of the enterprises and employees, usually represented by employers' associations and trade unions. In most transformation countries these actors have not yet adequately consolidated their position. The actor gap(12) this entails is, in part, an invitation to the creation of fictitious solutions and, in part - given a strong ideological discrediting of state control - to an uncritical surrender of financing and medical-care functions to market forces. The laborious path of simultaneous development and qualification on non-state, social-policy actors "on the job" is required.

From this complex problem situation there follow six matters for international technical cooperation and political consultation:

- The dominant orientation of projects of international cooperation to a transfer of technology and control know-how requires underpinning by social and health-policy qualifications in which the productive social power of equity, socially organised solidarity and client orientation is imparted.

- Projects involving technical cooperation mostly tend to see the institutions and human resources in the transformation countries as raw material for the construction of western financing and control models.[13] But the mostly habitualised experiences with not only the Soviet type of care but also with the phase of radical change to date are not taken into adequate account either as fostering or as impeding conditions for the development of new views and the erection of new structures.

- The aforementioned problems as well as further problems involving a reorganisation of social and health policies can only be overcome in interactive processes with the partners in the transformation countries. The still prevalent practice of dispatching experts for a short time usually does not help and is based on an overestimation of the political and guiding effects resulting from experts' reports and seminars.

- The remodelling of the health system is only in part a central state task. Projects involving international cooperation will have to work in an even-handed way with NGOs, medical and nursing associations as well as employers' associations and trade unions and/or will have to support their growth.

- International cooperation can only start at exemplary points in the complex field of health-policy actors, problems and developments. For the indentification of suitable points of intervention it is necessary to apply criteria of strategic relevance, sustainability, synergy, freedom from contradictions and cultural compatibility.

- Combining and coordinating international cooperation in country-specific programmes, e.g. under the aegis of WHO, can help to focus strengths and cut frictions. But some of these combined projects are too complex and too rigidly interconnected. This is often due to an underestimation of the complexity and unpredictability of intervention in social systems, which are not, after all, trivial machines with clearly predictable input-output relations, there being no "one best way" to reorganise them. [14,15]

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Address for correspondence

Prof. Dr. Rolf Rosenbrock
Wissenschaftszentrum Berlin für Sozialforschung
Reichpietschufer 50
D-10785 Berlin
Germany
Tel.: +49 30 25491-571
Fax: +49 30 25491-556
ROSENBROCK@medea.wz-berlin.de

ASYLUM SEEKERS, REFUGEES AND HEALTH
- THE SITUATION IN DIFFERENT WESTERN EUROPEAN COUNTRIES

H.-Jochen Zenker, Zahra Mohammadzadeh, Thomas Hilbert

Although by the mid-nineties foreign migrants accounted for more than 8 per cent of the total population in the Federal Republic of Germany, there is still a definite lack of public recognition of this development and its consequences. Nor has official political discourse on social and health issues so far addressed the real situation of migrants in this country, neither has it been made a subject of public health or social needs research.

Up to the seventies so-called 'guest workers' who had been hired in Southern Europe and Turkey were rather naively expected to return to their home countries in due time, definitely after having retired from working life. As the years went on, however, politicians not only had to accept the immigrants' desire to stay, but had to face the fact that additional numbers of migrants were beginning to push for entry into the "secure" states of Europe for economic, political, ethnic, and religious reasons. Hundreds of thousands of so-called Germans by descent have annually immigrated from East European countries since the mid-fifties, taking their total number up to 2.5 million by 1994. The third component of today's migrant population in Germany is formed by war refugees and asylum seekers. Annual immigration by this group has varied greatly since 1980, but it topped 230 000 in 1990 and rose to a peak in 1992, with more than 400 000 people applying for political asylum in that year. The debate on immigration began to be dominated by arguments along the lines of "the boat" being "full". The Federal Parliament changed the constitution and introduced the so-called safe third country ruling. At the same time, Germany accepted 400 000 refugees from former Yugoslavia who are supposed to be repatriated.

It is hardly surprising, then, that the Federal Republic of Germany has a considerable gap to close in the effort to create supporting structures for foreign migrants, in particular as far as the general social network and education are concerned, but also in health and welfare.

While ten to fifteen years ago, health policies dealing with these groups hardly envisaged anything beyond defensive measures aimed at the protection of the indigenous population from infectious diseases, epidemiological studies today point to the fact that such strategies are of negligible importance. What is more, these studies stress the necessity of analysing migrants' specific health needs, and of covering existing deficits in a manner realistically tailored to those needs. There is evidence that the cultural background of the host country, its medical care system, and traditional conceptions of health and illness, are as important as the circumstances of migration, the migrant's legal and social status in the receiving country, and his or her living conditions there.

According to the Maastricht agreements, national health care systems and social networks are to be harmonised in the course of European unification. This seemed a good reason to look towards some of the Federal Republic's neighbouring states where more experience has been gathered on health care for asylum seekers and war refugees, and excellent models of practical intervention have been developed.

So in May, 1996, experts from Denmark, Sweden, Norway, the Netherlands, Switzerland and the Federal Republic of Germany discussed the supply systems in their countries, sharing information on legal and demographic backgrounds, available epidemiological data, living conditions, as well as health provisions and care.

National reports were to contain information on: the legal basis of residence; on differences of legal and social status; laws and regulations governing social and health care; demographical proportions and structure of immigrant communities; the type of "medical reception" each country performs; general health problems of asylum seekers and refugees; transmitted diseases; questions of living conditions in the receiving countries; prevention and health promotion as well as specific group problems like those of women and children; or traumatised persons.

The picture appearing from the national reports is far from uniform. While medical examinations and health checks are performed on arriving asylum seekers and refugees in all of the countries, the character of these measures is multifarious. In some countries, such as Denmark and the Netherlands, these checks are carried out by nurses; in others, such as Germany and Norway, doctors are involved from the start. On the other hand, Germany, and to a certain extent Switzerland, are federal systems in which autonomy at state level can lead to a relatively strong internal divergence, ranging from mandatory screening (including HIV - testing without consent) to counselling and primary health care measures. In the centralised systems of countries like Sweden and Holland, however, similar divergence can be found when comparing measures carried out by municipal and county authorities. The type and extent of the initial medical examination is divergent, too. It reaches from a screening of the newcomers for specific infectious diseases to a global physical examination combined with consultation on all health problems of the asylum seeker or refugee and treatment in the sense of a basic medical care. The concept of screening was widely discussed throughout the conference. In several countries the original screening, which consisted of mandatory X-rays and blood and stool samples, has been reduced due to both epidemiological, ethical, and budgetary considerations. In others, chest X-rays for tuberculosis and blood samples for hepatitis, although no longer compulsory, are still strongly "encouraged" by the reception system. As far as HIV is concerned, Sweden is probably the most conspicuous case of obligatory testing without necessarily safeguarding therapeutical measures at the same time, as many of the HIV positive cases belong to applicant groups with a very low recognition rate. With all these differences, participants of the Bremen conference agreed that the real problem connected with asylum seekers' and refugees' health is not the risk of them importing infectious diseases and thereby posing a threat to the indigenous population (a risk which is nevertheless paid attention to in all systems). The real problem is a complex set of risks endangering *the health of migrants* and resulting from a mixture of factors of the sending society, the cultural background, the migration process, and the conditions under which migrant communities subsist in receiving countries. In order to get a clearer insight into the interrelated problems of this complicated situation, sharing knowledge, experience, and opinion between experts from different countries (all confronted by the same issues) will be both professionally helpful and politically desirable.

Seen from the perspective of Germany, the neighbouring countries have a head start in both experience with immigrant health care and with the general state of the debate on social and health support systems, in a period of political pressure against immigration. Thus Denmark, for instance, allows asylum seekers to take on jobs. Their children in the school age bracket are obliged to take part in special lessons or join the community schools, just as is the case in Sweden and Norway. All migrant children are part of the Danish preventive system including dental care. The same is the case in Switzerland, where, on the other hand dental care for adults is not included in the otherwise obligatory *private* medical insurance which is taken out for the asylum seeker/refugee by the Federal Office of Refugees. Most of the Danish hostels are organised by the Red Cross which is also active in refugee health care in Switzerland. The Danish Red Cross pursues the objective of lodging health care for asylum seekers and refugees within the regular health care system. This objective is also targeted by the Dutch. In many countries - for example Sweden, Norway, Switzerland, and Holland - special centres have been put up to care for migrant groups with specific problems: women, unaccompanied children and youth, traumatised people, victims of torture and organised violence, HIV positive people and problem families.

In the Dutch national report, the clarity with which a humane approach was demanded impressed everybody - an approach which is apparently practised in the Dutch health care system for migrants in spite of xenophobic phenomena emerging from social problems in Holland just as they do almost everywhere else in Europe. As in Germany, 1989 presented a conjunctive in the Netherlands, with rising numbers of asylum seekers and migrants and a general discussion on the pros and cons of their social upkeep, finally leading to a criticism of existing support procedures and a restructuring of the system. Since then, basic needs are covered by the *Centraal Orgaan Opvang Asielzoekers (COA)*, the central organisation for the social support of refugees in whose 80 decentralised institutions approximately 450 doctors, nurses, and social workers are employed. As in Denmark, the procedure in case of illness follows a dual principle: acute and minor diseases are treated immediately while non-acute and major problems are dealt with on the adequate level of regular health care. As asylum seekers are not allowed to take up employment in the Netherlands(similar to Germany), facilities maintain libraries, sports equipment and other items necessary for leisure time activities. At present, the Dutch system is being restructured again, with the aim of assigning an even stronger part in the health care of asylum seekers and refugees to municipal health offices in co-operation with the institutions of the regular health care system.

The Danes intend to set up centres for groups with homogeneous or at least comparable cultural backgrounds, as the social network is seen to be very important for the individual's health. "The more you separate and fragment the people the more they need personal support". So if you make groups support themselves, it might be possible to reduce or even eliminate some of the problems, at the same time reducing the medicalisation of psychosocial factors, making health care more effective, and raising cost effectiveness too.

Strangely, with the exception of the German and Swiss delegates, participants were reluctant to draw the obvious conclusion of a *systematic* employment of qualified migrants in refugee health care. Switzerland gave a convincing example of imagination used for health promotion faced by communication barriers. In a refugees and asylum seekers health project in 1994, a theatre play was used to get across the basics of prevention and primary health care, especially in connection with infectious diseases like AIDS. Language communication was

seen as an important factor by all participants, suggesting medical professionals to bring their influence to bear on politicians to realise this context and give language programmes a higher priority. Sweden is a country where this has been done successfully. Apart from obligatory courses on Swedish language and culture, and special programmes for children in pre-school and school ages, the Swedes are in the process of building up a national network of interpreters. In that country, like in Norway, the employment of interpreters in medical examinations is obliged by law. Interpreting in medical contexts, however, as well as in psychosocial counselling, psychiatric interviews or therapies remains an unsolved problem in view of the multitude of sending countries and cultures.

In Germany, networks or databases on interpreter employment are only rudimentary and mainly borne by private organisations. The Norwegian and Swiss delegates confirmed the Bremen experience that interpreter employment at low levels of linguistic difficulty could be financed by municipal budgets but are not resorted to very much in practice. The overwhelming part of interpreting in refugee and asylum seeker health care seems to be contributed by fellow-inmates of hostels, friends, acquaintances, children and unqualified staff of practices and hospitals.

Viewed against the background of a sustained mobility of refugees and asylum seekers world-wide, conference participants agreed on a number of basic positions held to be essential demands

- to withstand political pressure to use medical procedures as either repressive instruments or palliatives for the indigenous population (as is widely apparent in non-medical arguments in favour of compulsory screening); and instead base health care on offers of consultation and care with a voluntary character and accompanied by intensified attempts to gather well-founded epidemiological information;

- to promote the exchange of experience and knowledge on the actual epidemiology, health status, and health care situation of migrant communities on a European level, especially with a view to the diversity of refugee and asylum seeker groups in the cultural and social context, but also in regard of legal status;

- to advocate acceptance of minimum standards - in fact any standards - of health care for asylum seekers and refugees on the level of standards valid in regular health care and with the eventual aim of integrating it into the regular health care system;

- accordingly, to advocate the financing of asylum seeker and refugee health care, instead of through special funds, through existing social and, where applicable, medical insurance systems;

- to argue for the intensified employment of qualified migrants in the support systems for asylum seekers and refugees, as this is seen as a means to decisively mitigate the problem of language and cultural communication barriers;

- to generally support those measures aiming at integrating the health care of the various groups of migrants into a comprehensive, internationally oriented public health conception;

- to continue the sharing of information on conceptual and structural developments in the health care of migrants as a precondition to harmonising the systems used in European countries, in accordance with the Maastricht agreements.

In a final resolution, the participants of the Bremen meeting expressed their deep concern over the decision by the Federal Republic in favour of an early start to the repatriation of Bosnian refugees, many of whom are suffering from open or hidden traumatisation consequences. They appealed to the state authorities responsible for repatriation procedures to support a delay of the measures in order to grant the refugees more time for mental and psychosocial stabilisation.

Adress for correspondence

Dr. Heinz-Jochen Zenker
Hauptgesundheitsamt
Horner-Str. 60-70
D-28203 Bremen
Germany
Tel.: +49 421 3616259
Fax: +49 421 36115554
jocri@aol.com

EVIDENCE-BASED-MEDICINE (EBM), MEGA-TRIALS AND NUMBERS NEEDED TO TREAT (NNT) AS IDEALS OF RATIONAL HEALTH CARE

Dieter Borgers

1. Background

The development of a unified and universal medical practice as a scientific and technological venture has reached a new stage:

- need for resources for relevant monitoring of therapeutic progress, which require funds of more than 100 million dollars and can only be supplied by the USA, multinational pharmaceutical industries or other organizations on this scale

- uniform standards for clinical research and uniform methods (protocols in the case of cancer, Consort Statement, drug regulation) (Schulz 1996)

- multicentre studies carried out simultaneously in hundreds of clinics worldwide (mega-trials) (Hampton 1992)

- continuous progress of the Cochrane Collaboration as a future data base of knowledge for clinical action (Antes 1995)

- MEDLINE as a present to mankind by the American Nation via INTERNET (1997)

- implementation of the randomized trial as the gold standard and favoured clinical instrument for the scientific validation of practice (Marks 1997)

- a pharmaceutical industry, which as a result of mergers over the last years consists of only few multinational companies and a biomedical research complex controlled by the National Institutes of Health of the USA (50% of all biomedical research funds worldwide)

- influence and prestige which few independent journals such as Lancet, BMJ, JAMA and New England Journal of Medicine enjoy all over the world among journalists and scientists, and the worldwide scientific monopoly of English as lingua franca

The concepts and rationalizations resulting from these developments will determine the medical future of mankind, of the healthy and the sick. Health policy and the practice of medicine are influenced heavily by emerging new technologies and only the mere lack of financial resources will be the reason for not being promulgated worldwide within a few months (Hirschel 1998). But phenomena generally introduced under the reality and metaphor of technological progress and science are only in few exceptional cases so effective that

they do not call for alternatives. In most cases, biomedicine struggles to combat chronic diseases with successes being so negligible and/or questionable, that often hegemonial interests are gaining ground without any relevant value for real life practice (Abholz 1980, Bunker 1994, Olshansky 1986).

The fragility of medical effects, above all with regard to long-term effects for chronic diseases, is generally masked by false authority and a kind of childlike belief in therapeutic miracles. David Sackett, one of the fathers of Evidence Based Medicine (EBM) recently indicated that the hasty mass application of the substances Flecainid and Amiodaron led to a drastic reduction in the life expectancy of the patients treated and (direct quotation) that the „two cardiac drugs killed more Americans than the Vietnam War“ (Die Zeit, 12 March 1998, p 40). The increased number of randomized long-term studies carried out in case of chronic diseases showed that influences on the long-term course of a disease (natural history) which were based on simple, linear prolongations of the acute disease model were hardly effective (e.g. chronic bronchitis) and/or were bought at the price of excessive medicalization with negative secondary effects on the quality of life and autonomy. The relative irrelevance of the treated biological parameters and the psychologic effects of the patient's fixation on his disease hence modified the strategies tested in acute diseases. In this way, a chronic production factor „medicine“ is a double-edged undertaking for health.

The realistic quantification of (positive and negative) effects is a primary target and basis of EBM (Hemingway 1997). In the tradition of the English empiricism and pragmatism the results of long-term studies produce quantitative evidence of effectiveness (Bucher 1996). From this point of view, EBM is the specification of a critical medicine which helps to develop a discursive political and practical reality of empirical outcome evaluation in contrast to authoritarian claims (Berger 1997, Kunz 1998). Although the randomized clinical trial is the preferred technical instrument for gaining knowledge, the empirical orientation operates on a broader basis and should be regarded as a „culture“ of quantification and evaluation (Raspe 1996, Feinstein 1997). The necessity of such a fundamental orientation makes the EBM movement a reform project which has long since been overdue.

The Federal Chamber of Physicians in Germany which recently held a symposium on this subject, expressed the view that EBM should be supported with regard to health policy and practical intentions. This allows the conclusion that an important aspect of critical medicine has now also reached this body. Since empirical quantification and pragmatic evaluation are not the only concern, this contribution is intended to analyse a specific aspect of the overall problem. The latter is characterized by a shifting of focus in which „chronic disease“ is seen as something isolated from the subjective feeling of the individual and replaced by a scientific programme for improving biological deficits. This backgrond against which EBM is to prove itself shall be described in the following.

2. Biomedical Ideals

Rational practical medicine owes its therapeutic effectiveness to communicative action and techniques of controlling nature (biomedicine). The ideal form of communicative action consists of the establishment of a personal doctor-patient-relationship, and understanding within the „medium“ of language. Its necessity is derived from the fact that suffering not only implies problems which can be solved by technologies, but also

comprises the complex dimension of human nature, and a patients diverse, unique and individual world of experience. For biomedicine as an example for a technological-scientific civilisation, the „real nature“ of man is nothing more than a complex machine of the living as a biological organism. Consequently, medicine today intends to control, manipulate and improve this machinery and its disturbances. Triumphant successes justify the necessity of a more and more complex, medically orientated way of life.

In this context, risk reduction, disease prevention, alleviation of pain and prolongation of life are unproblematic self-evidences. Merely historical and cultural taboos (e.g. gen technology) limit the practical interest. The manipulation of biological processes can be traced without any major difficulties because it is a „wertfreies“ endeavour. By addressing specific tasks, this „control“ of nature can prove to be successful or fail. If diseases could always be overcome, etiologies be removed or dispositions be eliminated, only to be confirmed by formal biometric experiments, criticism and a different vision of health to be achieved would not make any sense. Indeed, the overcoming of a disease is a metaphor which very seldom materializes in reality. The everyday medical routine in hospitals and practices resembles a „stage of siege“ of chronic pathologies which, because they cannot be overcome, lead to chronic treatment. Over the last decades, this medicine has developed in such a way that the acute disease model with its limited ambition of alleviating symptoms and providing medical treatment in a crisis situation quantitatively lost so much importance that it is now at the periphery of daily medical practice. The shifting of focus towards a chronic medicine as the centre of medical treatment is so important that most of the involved problems such as effectiveness, efficiency, the long-term impact of physicians on the way of life are discussed in theory but have led to few consequences in practice (Burris 1997).

The criticism of the relative inefficiency of long-term medical treatment has up to now mostly been based on the argument that a more continuous and improved permanent observation and treatment would lead to corresponding successes. Many practical reforms in health policy are and have been oriented towards this direction. Deficit analyses and critics of the real medical care situation keep calling for an improved continuity, improved coordination, more long term planning and further systematic and integrative strategies for a lifelong treatment. The problem of patients' lack of compliance has led to numerous efforts to optimize such therapies. There remains, however, the fundamental question whether the seleced strategies for treating the individual patient are effective and efficient in a specific sense. Specific here means that not general care and a possible social and psychic stabilisation of the patients is achieved by continuous treatment but that the biomedical techniques as such develop a universal and uniform effectiveness.

The EBM orientation, which has come into existence in the Anglo-American countries since the beginning of the 90s (Hemingway 1997), has the general objective of empirical and rational medicine with the initial impetus being given in obstetrics, where many practices were unveiled as a kind of magic of a pseudo-scientific medicine. Its main field of application in health policy and clinical medicine however has developed in the field of chronic medicine. The evidences of a chronic medicine unveiled by the EBM orientation are characterized by Mega-trials and Numbers Needed to Treat (NNT's) as methodical instruments. Before analysing these instruments, a practical reality shall be illustrated by giving an example.

3. Chronic Cardiac Insuffiency as an Example

The possibility of treating chronic cardiac insufficiency with Digitalis is a recent and good example to demonstrate the fundamental problems of on the one hand symptomatic approval or, on the other hand, a long-term orientation (prolongation of life, prospective risk reduction in medicine) (Fischer 1997). Particularly in Germany in the 1970s (and not only with regard to Digitalis treatment), a routine had developed which, by neglecting the conceptional difference between symptomatic and risk-oriented treatment, led to the routine-type Digitalis treatment of all patients over 65 years of age. The symptomatic effect of the drug which had long since been known and which consists in the improvement of the heart, was regarded as sufficient evidence for a lifelong causal therapy, addressing the progression of cardiac insufficiency with the aim of prolonging life. Based on this analogy, an extension of the indication to the geriatric heart (hence all old people) seemed plausible.
This general tendency to establish lifelong treatment routines and risk-oriented ways of treatment by drawing analogies is opposed by EBM by demanding, that in each individual case a relevant reduction of clinical events or a disease-specific prolongation of life by mortality reduction should be proved. The recently completed study by The Digitalis Investigation Group (1997) came up to these demands and hence was able to clarify a very old controversy in internal medicine. Whereas in the case of cardiac insufficiency, the acute and symptomatic effectiveness of Digitalis was undisputed, the effect of permanent treatment with the aim of mortality reduction and causal influencing of long-term prognoses remained open (Gheorghiade 1997).

In the perspective of lifelong treatments, the known toxicity of Digitalis led to risks which in the end could also lead to an increase in the mortality risk, hence to a iatrogenic effect. Thanks to the modern arsenal of multi-centric randomized long-term studies and the precision they allow, a clarification of this question seemed to be realistic. To prove a life-prolonging risk reduction, a randomisation of n=6800 and an average observation period of three years were necessary. Whereas evidence of a symptomatic effect can be furnished within a few weeks and with few patients and in the historic perspective the casuistic description of an effect was adequate. Fig. 1 shows the result of perfect correspondence of the general mortality risk between treatment and placebo group which in the same way was shown for cardiovascular mortality. A small numerical advantage with regard to severe heart failure was offset by an increased number of hospital stays due to cardiac arrhythmia. A doctor treating 100 patients over a period of one year can only avoid one single case of hospitalization without at the same time being able to influence the mortality risk. Quality of life and an alleviation of symptoms are the only rational objectives for treatment which have to be analysed in each individual case whithout a universal therapeutic-ethical mandate for treatment in general (Packer 1997).

With regard to the overall medical problem in most cases of chronic disease, this categorically clearly negative result achieved for Digitalis is the exception. The quantitative reality of the published long-term studies in different fields of therapy for different risks, diseases and intervention techniques consists of in most cases formally „positive“ results, i.e. stochastically founded reduction of clinical events. In most cases there are no categoric yes/no decisions but problems of quantitative assessment which lead to answering the question, as to whether the treatment is „worth the effort“. The technical measurement is the so-called NNT (the number of

patients to be treated to avoid an event, NNT = Numbers Needed to Treat). The correct calculation of this figure is a central concern of EBM. Supposed, in the studies the Digitalis treatment had proved an advantage of surviving (corresponding to the number of hospital stays) then a doctor would have to treat 100 patients over a period of three years to avoid one single death over this period of time; 99 patients would be treated in vain.

Due to the categorically negative result, evidence-based symptomatic treatment of cardiac insufficiency as a chronic disease does not pursue a hidden programme of prolonging life. It is a medicine of the chronically ill patient but not chronic medicine to improve biochemical or physiological deficiencies, not wanting to distinguish between the abstract prolongation of life and ill health. If in most diseases the outcome of the majority of the studies is positive, a quantitative measurement for their relevance has to be found. This quantification invariably leads to a problem of stochastic effectiveness. This stochastic, i. e. in the individual case almost accidental effect of an intervention, is a fundamental problem of medical action. The negative results achieved in many ambitious long-term interventions however suggest that the limits of practical reason have been exceeded.

4. Person-related Medicine as Stochastic Practice?

The possibility that an abstract numeric figure referred to as NNT could become the guiding star of a scientifically legitimized effectiveness of medicine with regard to chronic diseases looks like the potential reality of a medical roulette representing itself as a scientifically based practice (Vandenbroucke 1996). Telling a patient (and this is the actual theory and practice of EBM) that a five-year-treatment will have a chance of 1:100 of taking effect would, according to average comprehension, imply the opposite of effectiveness or scientific approach. Since there is a 99 times chance of ineffectiveness and just one single chance of effectiveness, the impact of the treatment on the individual and his fate would be nearly accidental and would only be appropriate in desperate situations. The normal understanding of doctors (and patients) is based on the assumption that a medical therapy, although it does not have to be effective in each individual case, will in general be effective. Even the probability that in very few individual cases a therapy could have the opposite effect would still be admissable; but if the regularity of an effect falls below a 1:1 ratio (hence 50% of the cases) or if it achieves the ratio of just one effect compared to 99 „non effects“, this view would imply a dangerous proximity to quack medicine or charlatarism. Translating this problem into (cost) considerations on the benefit-risk ratio in terms of health policy can best be achieved by the analogy in which a psychologically oriented permanent treatment of 5 years would only help every 99th patient - an inefficiency which would even be rejected by the concerning professional association.

The concept of calculating NNTs in the case of chronic diseases leads to a realism in terms of efficiency which in the communicative situation of the traditional doctor-patient relationship of course involves many problems.Confidence and reliance in medical treatment as a fundamental prerequisite for therapies are counteracted at the material level. Based on psychologic criteria Abholz proposed a classification in doctor/consumer and doctor/patient relationship which from the pragmatic point of view seems to be adequate (Abholz 1993).

The demonstrated paradox of an EBM, which in its central field of application is a stochastic medicine cannot be avoided from another point of view because each belief in a principally safer and more effective medicine (which always helps) seems like childlike faith (Matthews 1995). By taking the example of cardiac infarction via cancer treatment to orthopaedic problems and many other chronic pathologies it can be illustrated that medical interventions can have impacts which, with regard to the successful avoidance of intended long-term clinical targets often lead to a risk-(and/or event) reduction which includes a 30% relative reduction. In the idealized example of a controlled clinical trial in which all control experimentees will contract a disease later on and in the therapy group no more than 66% (hence a relative risk reduction of about 30%) this would lead to a NNT of 3, i.e. in every third case the patient would be helped. If on the other hand a health risk of 1% were taken only every 333rd experimentee would be helped. This example shows that the NNT is not determined by the effectiveness of the treatment but by the health risk given per se. When determining the NNT which would justify a chronic medicine to offset its negative aspects this is not so much determined by the effectivenss of treatment but by the given health risk. Whether the chosen therapeutic means has a relative effect of 20%, 30% or 60% is of secondary importance. The NNT calculation and the ensuing judgement as to whether treatment is worth the effort or not therefore is not so much a judgement on the effective possibilities of treatment but on the problem as to when person-related medicine is appropriate.

Its employment will lead to a technically correct quantifying assessment of the effectiveness, but at the same time it legitimizes and allows a shifting of objects as legitimate medical practice. Because this also means equating disease with a risk-oriented biological improvement programme, it is necessary to focus considerations on the importance of this process. In clinical routine, this transition is concealed because the ultimate reason of all treatment is the reduction of risks and hence the objectivation of the disease implies a quantification of risks. Which extent and nature of risks call for medical treatment is the question to be answered.

5. Cosmology of Health Risks as a Mandate for Treatment

The NNT is the reciprocal value of the absolute risk reduction; hence a risk reduction of 1% leads to a NNT of 100, a risk reduction of 0.5% to a NNT = 200 etc. In this way the figure qualifies the effect by relating it to patients treated in vain, without success and even to those treated wrongly, hence those patients who should have received no treatment at all. It is the „artefact“ of an instruction which reduces the result of an action (therapy) to a Yes/No answer; if the result is measured as a gradual improvement or deterioration it does not make sense and/or includes a superfluous dichotomization (good health/ill health), where a continuum provides better information (e.g. average reduction of temperature, average alleviation of pain etc). In this case there will be no patients treated in vain, but only stronger or weaker individual effects, and/or the usual therapy failures as an exception. In this way the practical NNT application could seem to be an operation which constructs an artificial satistical result, when in reality all patients receive help. This argument out of the dilemma is not possible because no other relevant criterion constitutes the future disease than its actual onset. The therapy of biological substitute parameters (surrogates) is a usual procedure but for an EBM no objective of therapy because they only represent risk factors, and the question as to whether their present and long-term reduction will make sense is justified only by the risk reduction of the later event. Hence the NNT is exactly the right answer to the actual problem. Conceptionally, there is nothing to treat apart from the risk of real disease. The stochastic (i.e. the non

regular) aspect of medicine in general differs from this problem in that there is never an individual guarantee for effectiveness. There will always be patients treated in vain. The existential situation of a patient seriously ill or directly threatened with death leads to the application of medical therapies on which all hopes are concentrated with a NNT beyond 100 or 1000. But because in the short and long run as well as individually and depending on the social context, ill health and a shortening of life are always a menace, the later analysis of the Mega-trial represents an exercise which eliminates individual effects in an abstract population-related risk reduction.

Separating the mandate for treatment of a person-related medicine from the direct experiences of the patient and doctor implies the development of a medical object which primarily consists of scientifically „constructed" long-term risks. Scientifically constructed here means that the systematic observation of large groups over long periods of time unveils such future risks and/or courses of a disease as shown by the Digitalis example for mortality risks. The more extensive and longer lasting such studies are, i.e. the further remote (e.g. more than 5 or 10 years) and smaller effects (risks) are regarded as worth the effort, the smaller the risks on which person-related clinical medicine concentrates (Charlton 1995). In principle there are no limits to a medical risk society thus evolving and asymptotically approaching a modern cosmology from which there will be no way out seen from the point of view of a „non-medical" way of living. This development is most advanced in the field of medical risk factors for cardiac infarction. The cholesterol depressant drugs (statines) which were for the first time admitted in Germany in January 1998 for the so-called primary prevention (up to now semantically only admitted in the case of an existing disease) is the model-type implementation of equating health with disease. In this case, the last two major long-term studies (Lipid study n = 9000, AFCAPS-study: n = 7000)were stopped in 1997 for ethical reasons because risk reductions of cardiac infarction with long-term medication could be achieved. If the historic view of the development of randomized studies shows that their N from 10 via 100 to 1000 and today 100 000 was followed from their medical practice a corresponding development is logical and inevitable if the trends of the last 30 years are continued (Borgers 1995). Studies carried out on cancer chemoprevention (Henderson 1996) and the „Women's Health Study" (1 billion US $ research costs) for cancer, osteoporosis and cardiac infarction reflect even more ambitious aims. Developments leading into the direction over longer perspectives and smaller risks and among increasingly younger age groups, are the logic consequence.

6. Development of Mega-Trials

The history of the clinical trial as an objective instrument to prove the effectiveness of medical treatment started in 1950 (Marks 1997). The Thalidomid-catastrophy led to its official recognition because the admission of medical products by the state now depended on successfully carried out randomized trials. Against the background of methodical improvements, the RT has become a routinized instrument of drug-development and has nearly replaced all other methods of empirical clinical research (Abel 1997). Outside universities and research institutions a trial industry was set up in which the innovations of the pharmacological industry are examined. The request is made and/or has already been implemented in some specialised areas (e.g. cancer diseases among children) that every patient should at the same time be randomized in a trial and thus serve scientific progress. Today (1998) in connection with cardiovascular diseases 3000 ongoing clinical trials can be identified. To examine also long-term effects in cases of a low event risk, so-called Mega-Trials have been

developed (Hampton 1992). In these trials up to 100 000 persons are monitored and receive treatment over a period of 5 - 10 years. These figures are necessary to prove a stochastic significance for the usually postulated 30% risk reduction. The demand to carry out long-term trials in the case of chronic diseases is the result of safety aspects of long-term treatment and of the purely empirical view that the mere influencing of risk factors is not evidence of effectiveness. In this context, the UGDP-Trial and the Coronary Drug Project-Trial were milestones which on the one hand illustrated the enormous efforts needed and the real difficulties and on the other hand demonstrated with unexpected (negative) results that in the case of chronic diseases such a long-term surveillance was absolutely necessary.

In the Womens' Health Study, the epidemiologic-clinical observation and the randomized clinical trial today reach a new historic dimension. In a 15-year study with N = 167 000 women between 50 - 79 years of age first the development of risk factors for cancer, osteoporosis and cardiovascular diseases is examined and secondly a hormone therapy, nutrition advice and a calcium medication tested in several sub-categories using a double blind design. (The Women's Health Initiative Study Group 1998). Since 50% of the examined women of this age have no uterus any more, the hormone substitution consists of two different doses and substances. The end points to be evaluated for the significance tests are: breast cancer, colonic cancer, coronary heart diseases and femoral neck fractures. In case of a positive result the clinification of the mentioned health risks and/or determinants of a disease carried out in the study will lead to corresponding prescriptions in health care. If taking the experiences of the riskfactor-oriented epidemiology of the cardiovascular system as an example, the WHI is only the natural continuation. Its new dimension consists in the combination of cancer, arteriosclerosis and osteoporosis in one study, secondly in the multiple medication and thirdly in the fact that higher age groups are concerned and also in the longer observation periods. Related to relative and absolute health risks the new type of patient this empirical experience may produce is even more a healthy woman in need of lifelong therapy. The clinical world in which these studies are carried out as marathon trials corresponds to the later practice of a correspondingly structured lifestyle. The NNT's justifying such a therapy correspond to the above-mentioned figures. The qualitative and quantitative difference to the established clinifications of blood pressure and cholesterol is not very pronounced. If today in Germany it has become routinized practice among cardiologists and even GPs to force for example 60-year-old women with cholesterol values of 300 mg% to undergo medication by resorting to the threatening gesture of an immediately imminent infarction this is perhaps no more than the starting point of a more extensive programme. In this programme there is no category which does not constitute a 30% risk reduction proved by a randomized clinical trial as a reality which needs medical treatment. As to the more general question of how society and politics should deal with health and ill health and which place personal medicine should take the described shifting of objects in medical treatment leads to more and more remote diseases and to the usurpation of the health motive into a clinical sphere (Domenighetti 1994). If for example NNTs of 100 are established as „significance levels" for medical long-term interventions, a medical usurpation of risks would lead to a comprehensive medical dietetic as an art of prolonging life. In practical discourses medical products, chirurgical operations, changed diets, moderate consumption of alcohol (Doll 1997), social interventions and changes are then suddenly referred to as risk-reducing factors having the same effect. If these discourses are held in clinical settings (doctor's practices) it is a natural fact that in most cases interventions which are more appropriate from the „medical" point of view will be implemented.

7. Conclusions

With regard to clinical routine, EBM translates a critical approach into practice which has always been the ideal of rational medicine. For David Sackett, this means that on the ward round clinical decisions are made with the help of online-connections on the ward trolley and direct search in original literature and/or in the Cochrane Library. The possible gadgetry in this can in future be replaced by professional information systems. Clinical information systems such as electronic patient files will contain knowledge-based tools for making decisions for which the Cochrane Library will then provide the basis. The technological aspects of a more direct and detailed acquisition and processing of information may easily turn out to be an end in themselves so that more comprehensive problems are ignored. So for example the discrepancy between searching for and providing information within seconds and the fact that the decision implies lifelong therapy for which the family doctor has to bear the responsibility, is an obvious contradiction. A reasonable solution could be not to start such therapies at all in hospitals but to discuss the criteria of an EBM in the doctor's letter and to recommend a treatment to the family doctor. Not adressing these problems in books on EBM points out the reduced version of ideal of technological intelligence. When quantifying effects, it is in the same way necessary to always consider the total reality of the „patient" and to become aware of the individual implications as the abstract application of risk reductions (as personal medicine) will lead to contradictions that cannot be resolved.

At the other end of the spectrum there is the role EBM plays for health policy. To use a term by Schwartz (1994), this role will consist in the „clearing out" of ineffective, damaging and superfluous treatments based on Technology Assessment (Schwartz 1994). This is a large terrain for EBM and the discussion about the IGEL list (individual health services) of the Association of Statutory Health Insurance Physicians shows to which economically motivated politics EBM leads, although it has hardly begun. Problems however will be entailed by a view which considers the political and cultural system of health care as something that can be understood via technological-scientific criteria of effectiveness (Berlinguer 1982). If EBM exclusively considers diseases and risks as objects to be treated, then a preliminary decision has already been made that a patient is not more than the material carrier of these realities. But if the reality of medical routine, particularly in outpatient primary health care consists of communicative action in which definitions of diseases and diagnoses are tools for understanding and only exceptionally constitute facts which can be found out by technological intelligence these facts should be of central importance for a conception of the health system and its political control (Uexküll 1991, Engel 1977, Schäfer 1994).

The empirical realism of EBM becomes obvious in a medical environment dominated by technological solutions. In this way, by its demand for more efficient methods, there is the possibility to only promote these technologies in their more efficient versions. If such a view is gaining ground as a political idea of what constitutes a health system a congruence with the neo-liberal view of society is achieved. Here as well management and policy are only instruments to establish and implement mechanisms which are more efficient from the technological point of view. The failure to appreciate social aspects and the character as a politically structured system of communicative action then leads to ignoring what this encompasses: communicative understanding, language, time, giving advice, solidarity, support by the environment, social relations etc. Separating such services from the health system invariably will lead to increased technological fetishism or other fetish-type phenomena (Kühn 1993).

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Address for correspondence

PD Dr. Dieter Borgers
Landesinst. für den Öffentl. Gesundheitsdienst
Westerfeldstr. 35
33611 Bielefeld
Germany
Tel.: +49 521-8007248
Fax: +49 521-8007200

HEALTH CARE AND THE COMMON MARKET

Adriana Ceci

Hans Ulrich Deppe

Finn Diderichsen

Birger Carl Forsberg

Eva Hansen

Julian Tudor Hart

Steve Iliffe

Arthur Keefe

Jens-Uwe Niehoff

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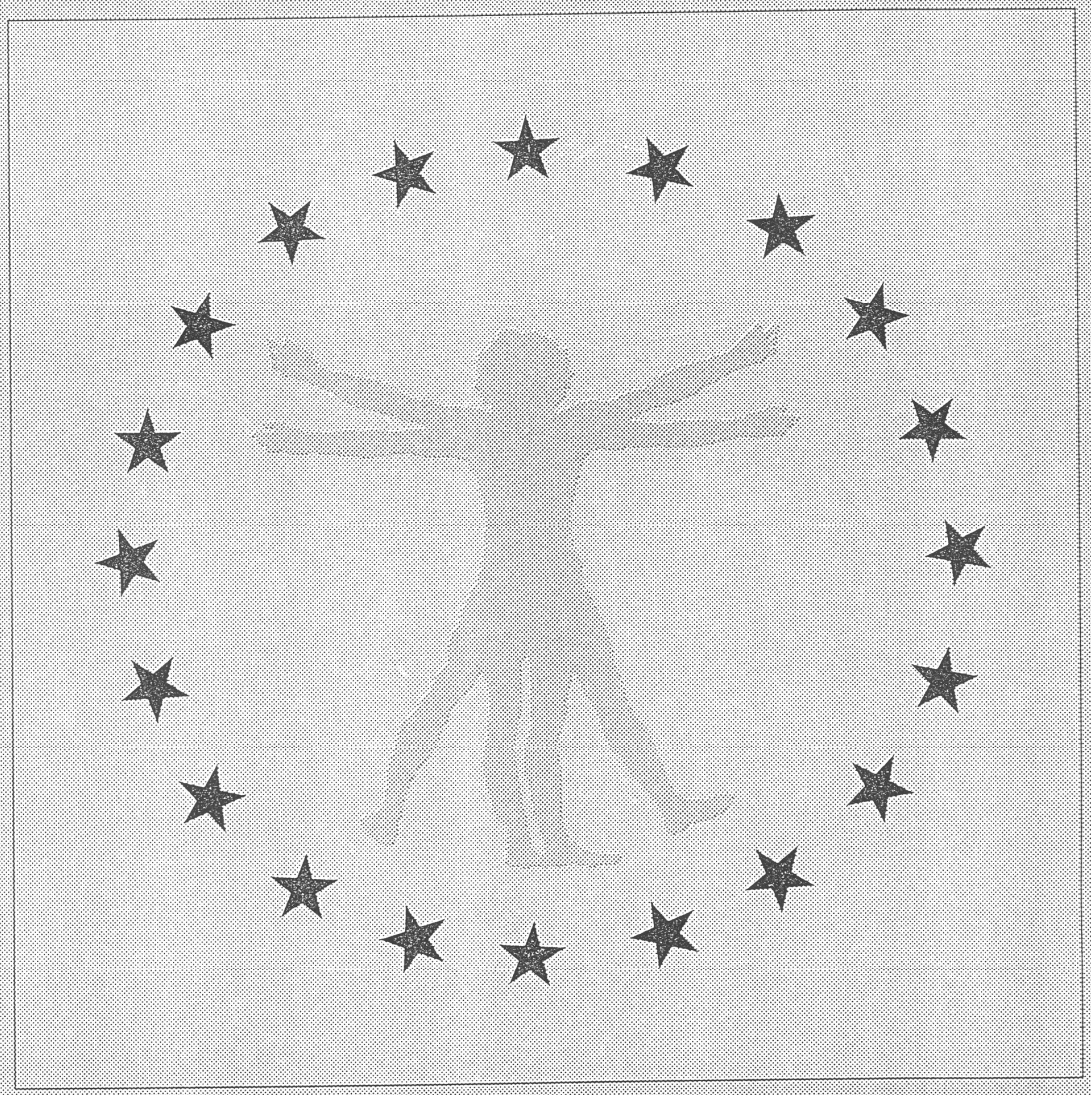

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